600 SERVICES

601 Overview

This chapter describes each long term and acute care service provided by the Division. It further provides a description of each service including the who, what, where, how and when of the service provision, the provider type and training required, and the service limitations and exclusions (non-Long Term Care Services covered services are available based upon the availability of State funds). It defines the delivery system for acute care services.

The Arizona Long Term Care System (ALTCS) provides funding for certain services based upon assessed needs and medical necessity. ALTCS does not provide day care or educational services. Individuals who are no longer eligible for ALTCS may be eligible for Transitional Waiver services. Transitional Waiver services include all Home and Community Based Services under ALTCS and supported employment. The Transitional Waiver is a program for individuals who were eligible for the Arizona Long Term Care System and have improved either medically, functionally or both to the extent that they are no longer at risk of institutionalization at a nursing facility or Intermediate Care Facility for the Mentally Retarded level of care. The Transitional Waiver does not cover institutional services in excess of 90 days.

Based on assessed need, the Individual Support Plan/ Individualized Family Services Plan/Person Centered Plan (Planning Documents) drives what services, types and amounts of support an individual may receive. The person with a disability may request the Planning Team to help them identify what their needs are, the best ways to meet those needs and what the primary caregiver(s) is willing and able to do. Often a person's services needs may be met through natural supports (such as relatives, friends, places of worship and local community resources). A contracted service provider may also be used. Though funding for services through ALTCS is not intended to replace what families currently provide, under certain circumstances parents or family members may be paid to provide services that support home and community living.

601.1 Family Members As Paid Providers

In some situations, family members may be paid to provide certain services. Immediate relatives permitted to provide service include the following:

a. Natural Child

b. Natural Sibling

c. Adoptive Child

d. Adoptive Sibling

e. Stepchild or Stepsibling

f. Father-in-Law, Mother-in-Law, Son-in-Law, Daughter-in-Law, Sister-in-Law, Brother-in-Law

g. Grandparent or Grandchild

h. Spouse of Grandparent or Grandchild

Immediate relatives not permitted to provide services include:

a. Husband and Wife

b. Natural Parent (under age 18)

c. Step Parent (under age 18)

Certain requirements are specific to family members who may be paid to provide supports to their family member with a developmental disability. They include:

a. Parent/Step Parents may only be paid for an adult child (over age 18). Other family members of an adult or minor who meet certification requirements may be paid to provide services.

b. A spouse of a person with a developmental disability may not be paid to provide services to their spouse.

c. Guardians of children under age 18 may not be paid to provide services to their ward except under extraordinary circumstances such as high support or medical needs and must be approved by the Assistant Director.

d. The Planning Team must determine the type and amount of services the person needs within their home environment. This determination is based on assessed need as well as the availability of natural and community resources.

e. Family members cannot be paid for skilled care during the provision of services such as Attendant Care or habilitation (skilled care is defined as G-tube insertion and feedings, catheter replacement, respiratory treatment such as SVNs (Small Volume Nebulizer) or suctioning tracheostomy care etc.

f. No single Family member may be paid to provide more than 40 hours of service per week. This maximum of 40 hours per week does not limit another family member from providing services. For example, an adoptive sibling may provide 38 hours of services and the grandparent may provide another 12 hours of service.

g. Family members must comply with all requirements in their contract in addition to all policies, procedures, laws and rules.

h. Primary caregivers/parents may not be paid to provide respite.

i. Services shall not replace care provided by the person's natural support system.

j. For a family member to be paid to provide supports and services, the individual must have medical or physical needs and one of the following circumstances must exist:

1. The Family member has been paid previously as the provider.

2. The individual was living in an adult developmental home, group home, intermediate care facility for the mentally retarded, nursing facility or other out of home placement and if assessed as appropriate, with supports and services, he/she will be able to return home.

3. The individual was already receiving in-home supports and services and a family member who is working, wishes to stop working and provide the supports and services for pay. The Division considers this manner of service provision as a change in employment.

k. Family members shall participate in and cooperate with ongoing monitoring requirements by the Division.

l. Qualified family members may become certified home and community based services providers by meeting the certification requirements, as applicable.

602 Services

The following section contains information about services available either through the Arizona Long Term Care System (ALTCS) or the State only funded programs administered by the Division. Each eligible individual will receive services in accordance with documented needs and availability of State funds.

Although the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan processes identifies needed services, individuals who are eligible for ALTCS shall receive information regarding their right to receive services as authorized. Individuals who are eligible for ALTCS shall also receive information regarding the appropriate Division staff to contact if services are not provided as scheduled. The Support Coordinator must assess with the individual their needs, the risk to the individual if a gap in services were to occur and develop a

contingency plan in the event of a services gap. These needs and risk factors are determined at the time of the initial and quarterly (90 day review) assessments. The Support Coordinator shall also explain the guidelines regarding the Divisions process (including a time estimate) for providing services when there is a service gap. The Division tracks and trends these gaps in services per the Arizona Health Care Cost Containment Systems (AHCCCS) contract requirements. The Division also submits a semi-annual report and other necessary reports to the Arizona Health Care Cost Containment System (AHCCCS) summarizing trends, services gaps and related grievances.

Primary care givers are not required to be in the home during the delivery of services unless one of the following situations exists:

a. The primary care giver provides "skilled care" and the service being provided is non-skilled care. In this case, the primary care giver would need to perform any "skilled care" that the provider is not certified/licensed to do.

b. The intent of the service as documented on the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) is to facilitate the primary care giver's ability to work with the consumer. As an example, the service is intended to directly train the family in learning how to respond to behavior problems.

Each person must be evaluated on an individual basis to determine medical necessity as well as the least costly level of care that will achieve the desired results.

Only nurses or respiratory therapists can provide skilled care. For example, skilled care includes Jejunum tube insertion, catheter replacement, respiratory treatment such as SVNs (Small Volume Nebulizer) suctioning, tracheostomy care etc.

Guidelines for services and evaluation criteria are found in the Service Authorization Matrix. This information is located in local Division District offices.

The source information regarding each service is found in one of the following documents:

a. Chapter 42 Code of Federal Regulations.
www.gpoaccess.gov/cfr/

b. Arizona Health Care Cost Containment System/Arizona Long Term Care System (AHCCCS/ALTCS) Program Management Policy and Procedure Manual.
azahcccs.gov/Regulations/

c. A.R.S. §36.
azleg.gov/ArizonaRevisedStatutes.asp

d. The Division Service Specifications.

602.1 Attendant Care

602.1.1 Service Description and Goals (Attendant Care)

This service provides a qualified attendant to assist a consumer to attain or maintain safe and sanitary living conditions and/or maintain personal cleanliness and activities of daily living. The goal of this service is to assist the consumer to remain in his/her home or participate in community activities.

602.1.2 Service Definition (Attendant Care)

Barring exclusions noted in Section 602.1.6, Attendant Care may include the following:

a. Safe and sanitary living conditions. These living conditions shall be maintained only for the consumer's personal space or common areas of the home the consumer shares/uses.

b. Tasks to maintain safe and sanitary living conditions may include:

1. Dusting

2. Cleaning floors.

3. Cleaning bathrooms.

4. Cleaning windows (if necessary to attain safe or sanitary living conditions).

5. Cleaning oven and refrigerator (if necessary to prepare food safely).

6. Cleaning kitchen.

7. Washing dishes.

8. Changing linens and making beds.

9. Routine maintenance of household appliances.

c. Washing, drying and folding the consumer's laundry (ironing only if the consumer's clothes cannot be worn otherwise).

d. Shopping for and storing household supplies and medicines.

e. Unusual circumstances may require the following tasks be performed:

1. Tasks performed to attain safe living conditions:

– Heavy cleaning such as washing walls or ceilings.

– Yard work such as cleaning the yard and hauling away debris.

2. Assisting the individual in obtaining and/or caring for basic material needs for water heating and food by:

– Hauling water for household use.

– Gathering and hauling firewood for household heating or cooking including

sawing logs and chopping wood into usable sizes.

– Caring for livestock used for consumption including feeding, watering and milking.

3. Providing or insuring nutritional maintenance for the individual by planning, shopping, storing and cooking foods for nutritious meals.

f. Assisting with showering, bathing, toileting, dressing and shampooing.

g. Assisting with transfer to and from wheelchair and/or bed.

h. Assisting with eating, where the assistance may include reminding or encouraging the consumer to maintain intake; serving or bringing food to the consumer; preparing food for consumption through cutting meats or other set-up activities; and feeding the individual or assisting the individual with eating.

i. Assisting with routine ambulation activities.

j. Assisting with or performing routine nail and skin care.

k. Assisting with tasks necessary for the comfort and safety of individuals with movement restrictions (tasks that do not require medical or nursing supervision).

l. Assisting the individual with special appliances and/or prosthetic devices, if the procedure is routine and well established.

m. Training the individual, family members and/or friends in personal care tasks as appropriate and available.

n. Referring for appropriate action all individuals who present additional medical or social problems during the course of the service.

o. Assisting with self-medication or medication reminders.

p. Supervising or transporting the individual as a complement to all activities noted in this section when supervision or transportation is not the primary goal of the service.

q. Establishing a structured schedule that meets the individual's needs.

602.1.3 Target Population (Attendant Care)

It is important to remember that support needs should ultimately be based on an assessment. Using the assessment and plan development processes described in Chapters 700 and 800, the person with their Individual Support Plan/Individualized Family Services Plan Person Centered Plan team (Planning Team) should take into account the following factors when establishing the need for this service:

a. The consumer lives alone and is unable to meet specific, basic personal care needs due to severe physical disabilities.

b. The consumer lives alone and is temporarily unable to meet basic personal care needs due to a medical condition or illness.

c. The consumer's basic care needs cannot be met by the primary caregiver(s) due to advancing age, a temporary or permanent documented physical or cognitive disability, or other limitation of the primary caregiver (physician documentation may be required).

d. The consumer's basic care needs cannot be met by the primary caregiver(s) alone due to intensive medical, physical or behavioral challenges which are result of the individual's disability.

e. The consumer, due to a medical circumstance, is unable to attend his/her normal service program, or

causes undue strain upon the caregiver(s) who in response requires additional supports.

f. The consumer's needs are not currently being met due to unavailability of service. Attendant Care may be used as an alternative service.

g. The consumer has medical or physical needs and one of the following circumstances exist:

1. The consumer was living in an Adult Developmental Home, Group Home, Intermediate Care Facility for the Mentally Retarded, Nursing Facility or other out of home placement and with Attendant Care, he/she will be able to return home.

2. The consumer was already receiving Attendant Care and/or Housekeeping and the parent, who is working, wishes to stay home and provide the service with pay.

602.1.4 Service Settings (Attendant Care)

Attendant care may be provided in the following settings:

a. The consumer's home.

b. The consumer's community.

602.1.5 Service Requirements (Attendant Care)

For consumers between the ages of 18 and 25 who will receive attendant care from a family member, a Person Centered Plan will be done as well as a personal, private interview between the Support Coordinator and the person. Upon documentation of the plan and interview, the Support Coordinator may authorize Attendant Care Family as determined by the service approval matrix. A written "Daily Living Schedule" must also be completed and reviewed with the Support Coordinator. Any amounts above those indicated on the service approval matrix must undergo review by Central Office.

a. Prior to initiating service, the provider shall meet with the consumer and their primary caregiver to obtain necessary information regarding the consumer, including obtaining a medical consent if the caregiver will not be immediately accessible, and completing the Attendant Care Agreement (Appendix 600.J).

b. The provider shall administer first aid and appropriate attention to injury or illness.

c. The provider shall report any unusual incidents to the Division in accordance with policies and procedures.

d. All Attendant Care Providers provision of care shall be monitored and assessed on-site no more than 30 days from the start of the service and every month for the first quarter.

The assessment must be performed on-site quarterly thereafter. A telephone call or review of the provider's progress notes is not sufficient.

Documentation of the on-site visit shall be maintained in the Support Coordinator's file.

e. The Individual Support Plan/Individualized Family Services Plan /Person Centered Plan team (Planning Team) must decide, prior to the delivery of service, who is responsible for monitoring and assessing the Attendant Care Provider's provision of care.

f. The Planning Team must address any potential issues regarding skin integrity. Examples include, but are not limited to, pressure sores, diabetes, tube feeding, braces and consumers who are in bed for the majority of time.

1. If, based upon Planning Team assessment and discussion, there are no issues identified regarding skin integrity, the decision should be stated in the Individual Support

Plan/Individualized Family Services Plan (Planning Documents).

2. If the Planning Team believes there is a chance of skin breakdown, the issue should be referred to the District Nurse for further review. Documentation of the assessment and recommendations shall be sent to the Primary Care Provider and a copy forwarded to the Support Coordinator.

602.1.6 Exclusions (Attendant Care)

a. Attendant Care shall not substitute for respite, day care or habilitation; such services shall not be changed to Attendant Care with the intent to provide reimbursement to the family members.

b. Attendant Care shall not substitute for a work, school or day program, however, Attendant Care may be used as an alternative for Day Treatment and Training only when Day Treatment and Training or Habilitation services are not available. Attendant Care, when used as an alternative, shall be used only until an appropriate service can be offered (not to exceed a six-month period). In the case where an available day program has been rejected, Attendant Care cannot be used as an alternative.

c. Providers of Attendant Care shall not perform the following tasks:

1. Cleaning up after parties.

2. Cleaning up several days of accumulated dishes.

3. Preparing meals for the whole family.

4. Routine lawn care.

5. Major carpet cleaning.

6. Caring for household pets such as walking the dog.

d. Attendant Care providers shall not provide cleaning to areas of the home not used by the individual, e.g., parents' bedroom or sibling's bathroom.

e. Attendant Care shall be offered only after the Individual Support Plan/Individualized Family/Person Centered Plan process has been completed and it is has been determined Attendant Care is the most appropriate service to meet the individual's need.

f. If the consumer is attending a day program provided by the Division provider, personal needs will be taken care of by the agency as part of the current service.

g. Attendant Care shall not be used to circumvent the Division residential licensing process.

h. Attendant Care shall not be used to supplant care provided by the individual's natural support system.

i. Attendant Care shall not be provided when the individual is hospitalized except prior to discharge to allow the individual to return to a safe and sanitary environment.

j. Providers may not perform skilled medical tasks.

k. Monthly progress reports validate continuing the service.

l. Attendant Care shall not be offered in a non-state operated Intermediate Care Facility for the Mentally Retarded, Nursing Facility Vendor Supported Developmental Home, Level I or Level II Behavioral Health Facilities or group homes.

m. An Attendant Care - Companion shall not exceed 20% of the provider’s weekly time on housekeeping duties.

29 Code of Federal Regulations Chapter V §552.6
www.gpoaccess.gov/cfr/

602.1.7 Service Provision Guidelines (Attendant Care)

Utilization of Attendant Care will be in accordance with the Individual Support Plan/Individualized Family Services Plan/ Person Centered Plan (Planning Documents).

Children in the age group of 0 to 3 need most of the tasks associated with Attendant Care completed for them by their parents/caretakers regardless of whether or not they have disabilities. There are some exceptions however, these exceptions must be listed in the Individualized Family Services Plan and reviewed by the District Program Administrator to establish the need for Attendant Care services.

The Authorization Requirements are determined according to the Service Authorization Matrix.

a. The consumer or family is expected to provide all necessary housekeeping supplies.

b. The consumer/family is responsible to provide money for supplies and food in advance of the purchase if the attendant is expected to shop for food and household supplies.

602.1.8 Provider Types and Requirements (Attendant Care)

Designated District staff will ensure all contractual requirements are provided. Additionally, all providers of Long Term Care Services must be certified by the Division and registered with Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.1.9 Service Closure (Attendant Care)

a. Attendant Care shall be terminated when the consumer with their Planning Team determines the service is no longer needed through the Individual Support Plan/Individualized Family Service

Plan/Person Centered Plan process including use of appropriate evaluations.

b. Attendant Care shall be terminated if the individual moves to an Intermediate Care Facility for the Mentally Retarded, Nursing Facility developmental home or group home.

c. Attendant Care shall be terminated when the primary caregiver(s) or other resources can meet the needs of the individual.

d. The consumer moves out of state.

e. The consumer/responsible person declines the service.

A Notice of Intended Action must be sent in accordance with the processes defined in Chapter 2200 of this manual.

602.2 Day Treatment and Training

602.2.1 Service Description and Goals (Day Treatment and Training)

This service provides specialized sensory-motor, cognitive, communicative, behavioral training, supervision, and as appropriate, counseling, to promote skill development in independent living, self-care, communication and social relationships.

The goals of this service are to:

a. Increase or maintain the self-sufficiency of eligible individuals.

b. Improve emotional and mental well-being.

c. Enable eligible individuals and their families to acquire knowledge and skills.

d. Ensure the availability to eligible individuals of information about and access to human services and community resources.

e. Develop positive relationships with and support for families.

f. Encourage family and consumer participation in areas of the program.

g. Recognize and acknowledge that the consumers (and families, if guardians) are the main decision makers in the delivery of service.

h. Ensure that programs optimize the health and physical well-being of the consumers served.

i. Provide opportunities for consumers to participate in meaningful community activities.

j. For early intervention, to partner with families to support the parent/child relationship as the primary relationship in the context of naturally occurring routines and activities the family identifies as priorities.

k. Produce outcomes of increased consumer skill development toward Individual Support Plan/Individualized Family Services Plan/Person Centered Plan consumer and family goals.

l. Assist consumers in achieving and maintaining a quality of life that promotes the consumer's vision of the future.

602.2.2 Service Settings (Day Treatment and Training)

Early intervention services for children age birth to 36 months of age and their families are provided in natural environments including the home and community settings in which children without disabilities participate. All other Day Treatment and Training may be provided in any setting and including during the school year and summer vacation. Day Treatment and Training may not be provided in an ICF/MR, child or adult developmental home or group home.

602.2.3 Service Requirements (Day Treatment and Training)

Before Day Treatment and Training can be authorized, the following requirements must be met:

a. The Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) must identify needs and outcomes consistent with the service description and setting.

b. Training and instruction must be pertinent to the present developmental, physical, mental and/or sensory abilities of the individual.

602.2.4 Target Population (Day Treatment and Training)

Using the assessment and plan development processes described in Chapters 700 and 800, the Planning Documents must determine the need for this service according to the following age categories:

a. Birth - 36 Months of Age.

Day Treatment and Training is appropriate when the family's concerns, priorities and resources identify that the developmental needs of their child would best be met by these supports.

b. Age 36 Months - 5 Years of Age

Generally children of this age range will receive this service from public schools in accordance with Part B of Public Law 105-17 (www.gpoaccess.gov/plaws/), however, the provision of Day Treatment and Training by the Division may be appropriate, in some instances, if all of the following conditions are met:

1. The Planning Document identifies needs above and beyond those identified in the Individual Educational Plan.

2. The additional hours of Day Treatment and Training would be reasonable and normal for

the child's age considering the number of hours the child is participating in pre-school programs and other out-of-home activities.

3. The child's developmental needs can best be met in a group setting.

4. Family and other community resources are not available to meet the need.

5. No other service is more appropriate.

c. (Five) 5 - 12 Years of Age

Generally, children with developmental disabilities will have their need for this service met by the public school system, therefore, most children will not need nor receive Day Treatment and Training during periods of time they are eligible for public education services.

Medicaid and the Arizona Health Care Cost Containment System (AHCCCS) does not pay for child care or respite as an alternative to Day Treatment and Training services for children 5 to 12 years of age. The provision of Day Treatment and Training by the Division may be considered for this age group if all the requirements for the 3 - 5 years age group are met and if the child needs to develop appropriate social and behavioral interaction skills and opportunities to integrate with non-disabled peers. If the Division considers Day Treatment and Training services for children 5 – 12 years of age, habilitation goals and objectives must be established and documented in the Individualized Family Services Plan/Person Centered Plan/Child and Family Team Plan.

The Division may also consider providing Day Treatment and Training services when the individual is eligible for the Extended School Year Program. This may indicate a need for Day Treatment and

Training to be provided in the summer. Habilitation goals and objectives must also be documented in the respective plans (referenced in "c" of this section) for Day Treatment and Training services for the summer.

d. 13 - Graduation from High School (18 - 22 Years of Age)

Generally, individuals with developmental disabilities will have their need for this service met by the public school system, therefore, most individuals will not need nor receive Day Treatment and Training during periods of time they are eligible for public education services. The provision of Day Treatment and Training by The Division may be considered for this age group if all the requirements for the 3 - 5 years age group are met. In addition, the Support Coordinator must determine that community resources are unavailable to meet skills identified in the Service Description and Goals Section, especially as related to independent living, communication and social relationships. If the Division considers day treatment and training for this age group, habilitation goals and objectives must be established and documented in the Individual Support Plan/Person Centered Plan.

e. Adults

Day Treatment and Training should enable individuals to increase their range of independent functioning and to refine their personal living skills. The service shall be age appropriate.

Consumers participating in Day Treatment and Training may also participate in Employment Supports and Services as part of a meaningful day.

602.2.5 Exclusions (Day Treatment and Training)

Exclusions include to the provision of Day Treatment and Training shall not:

a. Substitute for respite or day care.

b. Be used in place of regular educational programs as provided under Public Law 105-17. www.gpoaccess.gov/plaws/

c. Be used to provide other related services that have been determined in the Individual Education Plan to be educationally necessary.

d. Be used when another service, such as a vocational program or habilitation, is more appropriate.

602.2.6 Service Provision Guidelines (Day Treatment and Training)

Utilization of Day Treatment and Training will be in accordance with the Individual Support Plan/Person Centered Plan (Planning Documents).

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602.2.7 Provider Types and Requirements (Day Treatment and Training)

Designated District staff will ensure that all contractual requirements related to Day Treatment and Training providers are met before services can be provided. Additionally, all providers of Long Term Care Services must be certified by The Division and registered with Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.2.8 Service Evaluation (Day Treatment and Training)

The Support Coordinator must continually assess the quality of services provided to individuals with developmental disabilities as defined in the mission statement. In addition:

a. The provider must submit a written progress report on Individual Support Plan/Individualized Family Support Plan/Person Centered Plan (Planning Documents) outcomes monthly to the Support Coordinator. The report must address the presence or absence of measurable progress toward the individual's goals and outcomes. On a monthly basis, the Support

Coordinator must review these reports for progress toward outcomes. If there is no progress in the time period specified, the consumer with their Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Team) must reassess the outcomes and determine the on-going appropriateness of the service or outcome.

b. The Support Coordinator must perform a review of the Planning Documents as noted in Chapter 1000.

c. The provider must maintain a monthly activity schedule based on the goals and preferences of the persons' supported.

d. Materials, supplies and equipment used to deliver Day Treatment and Training must be furnished by the program and meet the needs of the individual and be age appropriate.

602.2.9 Service Closure (Day Treatment and Training)

Service closure should occur in the following situations:

a. Based on the consumer's progress, the Planning Documents should determine when goals have been met and the service terminated.

b. The consumer/responsible person declines the service.

c. The consumer moves out of State.

d. The consumer transitions to another age/skill appropriate service or program.

e. The consumer/responsible person/family can now meet the needs the service addressed, as identified in the Planning Documents.

A Notice of Intended Action must be sent in accordance with the processes defined in Chapter 2200 of this manual.

602.3 Employment Related Programs

602.3.1 Service Description and Settings (Employment Supports and Services)

These services provide opportunities for employment using several models to support consumers in a variety of job related settings.

a. Individual Supported Employment provides job coaching contacts at an integrated community job site with the employed consumer and/or employer. This service is to help ensure that the consumer maintains employment. Individual Supported Employment may also include job search services if these services are not available through Vocation Rehabilitation.

   Consumers receiving this service must not be a part of an enclave or work crew and must be paid by the employer. Individual Supported Employment is a time-limited service shall be provided on an individual basis and can be used for consumers who are self-employed.

b. Group Supported Employment is a service that provides consumers with an on-site supervised, paid work environment in an integrated community setting. Settings may include enclaves, work crews, and other integrated work sites.

c. Center Based Employment is a service that provides consumers a healthy, safe and supervised work environment. This service is provided in a Qualified Vendor owned or leased setting where the majority of the consumers have disabilities and are supervised by paid staff. The service goal is to provide consumers with gainful, productive, and remunerative work.

d. Employment Support Aide services provide consumers with the one-to-one supports needed to enable them to remain in their employment. These

supports can include personal care services, behavioral intervention, and/or "job follow along" supports, and may be provided in any of the above service settings, as well as a stand-alone service.

e. Split Programming may be appropriate for consumers who desire to participate in multiple employment supports and services. These services are billed hourly and based on team agreement and assessed need. Split programming is designed to fulfill the needs and desires of the consumer. Consumers participating in Day Treatment and Training may also participate in Employment Supports and Services as part of a meaningful day.

602.3.2 Transportation Services for Employment Related Programs

Transportation to and from work may be available to consumers receiving Employment Supports and Services, when such transportation is not available from community resources or natural supports.

602.3.3 Target Populations

Consumers who may benefit from supported employment as determined by the Planning Team (Individual Support Plan/Person Centered Plan team).

The Individual Support Plan/Person Centered Plan meetings and monthly progress reports from providers may be used as a means to identify the need for employment services. Participation in Individual Employment Plan meetings/School-to-Work Transition Planning meetings and the consumer's verbalized interest in employment may also identify the consumer's need for employment services.

The consumer with their Planning Team (Individual Support Plan/Person Centered Plan team) identifies the consumer's desires and dreams, employment goal and prior work history. In addition the role of the Planning Teams includes a description regarding the level of support needed and documentation of these

needs (including transportation) on the Individual Support Plan/Person Centered Plan.

Employment Supports and Services are available to consumers who are eligible for Arizona Long Term Care Services based on assessed need, and to State-funded only consumers based on assessed need and availability of funding.

602.3.4 Service Requirements and Referral Process

The Support Coordinator completes a Request for Employment Supports and Services packet when the Planning Team determines that a consumer may benefit from an employment related service.

This packet is then submitted to the Employment Program Specialist. The service code "VRI" shall be entered into the FOCUS system as part of the service plan and waiting list data as a current need. The outcome/objective shall also be added to the Individual Support Plan. The Employment Program Specialist reviews the referral packet and determines if the individual will go directly to Center-Based Employment or if the packet will be sent to Rehabilitation Services Administration/Vocational Rehabilitation Program.

Consumers/families who are referred to the Vocational Rehabilitation Program receive an orientation and complete an application. The Vocational Rehabilitation Program then determines eligibility for services. If eligible, services will be provided by the Vocational Rehabilitation Program.

The support coordinator should then take the VRI service off the wait list and open it as an indirect service.

If ineligible, the Vocational Rehabilitation Program will close the case and the consumer will be and referred back to the Division. At this point, the consumer with their Individual Support Plan team, including the District Employment Program Specialist, will reconvene to determine how best to meet the consumer's need for an employment related service. The VRI code should be removed from the wait list.

602.3.5 Service Provision Guidelines

Transition from the Vocational Rehabilitation Program to the Division of Developmental Disabilities

The Vocational Rehabilitation Program counselor notifies the Support Coordinator of upcoming transitions. The Support Coordinator then notifies the Employment Program Specialist of anticipated transitions. The Support Coordinator contacts the consumer/family and offers a list of Qualified Vendors. The consumer/family selects a Qualified Vendor. The Qualified Vendor is then notified and given an opportunity to accept or decline service provision.

When a Qualified Vendor is identified, a transition meeting with the consumer/family, the Vocational Rehabilitation counselor, the Support Coordinator, and Qualified Vendor is held to review the employment placement. This transition meeting is also used to review progress and services still needed by the consumer/family. The needed supports for the consumer's success and the date of transfer are also determined at the Vocational Rehabilitation transition meeting.

Authorization for Employment Supports and Services

The authorization process for Employment Supports and Services starts with the Support Coordinator adding the appropriate code to the Service Plan. The Support Coordinator then submits the authorization request to the District Designee. The District designee generates authorization for services.

The Qualified Vendor is informed in writing of service authorization and may only provide the services that have been authorized by the Division. Any change in services will require a new written authorization.

Service Changes

Any change in Employment Supports and Service, including changes from one employment service to another, or from an employment service to a different day service, requires Planning Team agreement and notification of the District Employment

Program Specialist. Progressive moves within Employment Supports and Services require a Request for Employment Supports and Services packet to be completed.

Tracking and Reporting

The Qualified Vendor is required to submit individualized monthly progress reports on Division forms to the Support Coordinator. The Support Coordinator ensures that Qualified Vendors submit required reports and will address reported issues.

The Support Coordinator will contact the District Employment Program Specialists if concerns cannot be resolved. The Qualified Vendor (QV) will submit a report on Division forms every six months to the Employment Program Specialist.

Monitoring and Technical Support

At a minimum, the District Employment Program Specialist will perform an annual on-site Quality Assurance Review of all Qualified Vendors who provide Employment Supports and Services. The Employment Program Specialist will also review the Qualified Vendors' "six month" reports, and provide on-site visits and technical support as needed.

602.4 Habilitation

602.4.1 Service Description and Goals

This service provides a variety of interventions such as special developmental skills, behavior intervention and sensorimotor development, designed to maximize the functioning of consumers.

The goals of this service are to:

a. Enable individuals to acquire knowledge and skills.

b. Increase or maintain self-sufficiency of eligible individuals.

c. Provide training/assistance in essential activities required to meet personal and physical needs.

d. Maintain the health and safety of eligible individuals.

e. Provide services in a manner that supports and enhances independence, self-esteem, mutual respect, value and dignity.

602.4.2 Service Settings (Habilitation)

Habilitation may be provided in the individual's home, a group home, a foster home, adult developmental home or other community settings, depending upon the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan outcomes.

602.4.3 Service Requirements (Habilitation)

Before Habilitation can be authorized, the following requirements must be met:

a. Training shall be based upon assessed needs with accompanying outcomes as developed by the Individual Support Plan/Individualized Family Support Plan/Person Centered Plan and skill attainment shall be stated on these documents.

b. The training outcome shall be a measurable transfer of skills from the trainer to the individual.

c. The provider may also train family members if the intent of the service, as written in the Individual Service Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents), is to facilitate the family member's ability to work with the individual.

d. As specified in the Planning Documents habilitation may provide training in the following:

1. Alternative and/or adaptive communication skills.

2. Training in self-help skills.

3. Training in physical mobility.

4. Training in adaptive living skills.

602.4.4 Target Population (Habilitation)

The Planning Documents must determine that needs cannot be met by the family, other financial resources or community supports. This is determined by using the assessment and plan development processes described in Chapters 700 and 800.

Additionally, consider the following:

a. Individuals living independently. Generally, individuals living independently possess the skills necessary to function at a minimum level of self-sufficiency. Typically, these individuals will not need, nor receive habilitation; however, it may be necessary to provide short-term habilitation for needs which cannot be met through the education or adult day program.

b. Individuals living in family settings.

c. Individuals with disabilities who are living independently in their family's home are generally expected to receive skilled training oriented toward increased self-sufficiency from their family without government assistance. Again, these individuals will not typically need or receive Habilitation; however, it may be necessary to provide short-term habilitation for needs that cannot be met through the education or adult day program. The individual may also need skill training over and above that which is considered in the Individual Education Plan (IEP) to be educationally necessary.

602.4.5 Exclusions (Habilitation)

Exclusions to the provision of Habilitation include, but are not limited to:

a. Habilitation shall not substitute for respite or day care.

b. Habilitation shall not be used in place of regular educational programs as provided under Public Law 105-17. www.gpoaccess.gov/plaws/

c. Habilitation must not substitute for day programs, i.e., Day Treatment and Training or school programs.

d. Habilitation is prohibited during the school hours as determined by the public education agency or the hours of home schooling.

e. Habilitation shall not be used when another service is more appropriate.

f. Habilitation goals and outcomes shall not be changed without referring to the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) including addendums or revisions.

g. Hourly habilitation shall not be offered in vendor supported Child Developmental Foster Homes or Adult Developmental Homes unless the following are met:

1. There is a specific issue, problem or concern that is believed to be temporary or short term.

2. The Planning Document must outline specific, time limited goals/outcomes regarding the service to be provided.

3. Monthly progress reports validate continuing the service.

602.4.6 Service Provision Guidelines (Habilitation)

For individuals living at home and attending either a school or a day program, the Division will consider habilitation services for intensive training purposes not to exceed 2 hours per day as

determined by the Service Authorization Matrix. Habilitation for intensive training purposes cannot be provided before, during or after the school hours as determined by the public education agency.

Utilization of Habilitation will be in accordance with the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents). The Service Authorization Matrix determines the approval requirements for routine habilitation.

602.4.7 Provider Types and Requirements (Habilitation)

Designated District staff will ensure all contractual requirements related to Habilitation providers are met before the service can be provided. Additionally, all providers of Long Term Care Services must be certified by The Division and registered with Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.4.8 Service Evaluation (Habilitation)

a. The provider must submit a written progress report on Individual Support Plan/Individualized Service Plan/Person Centered Plan outcomes monthly to the Support Coordinator. The report must address the presence or absence of measurable progress toward the individual's goals and outcomes. On a monthly basis, the Support Coordinator must review these reports for progress toward outcomes. If there is no progress in the time period specified, the consumer with their team must reassess the outcomes and determine the on-going appropriateness of the service.

b. The Support Coordinator must perform a review of the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) as noted in Chapter 1000.

c. The provider must maintain a monthly activity schedule.

602.4.9 Service Closure (Habilitation)

Service closure should occur in the following situations:

a. Based on the individual's documented progress, the consumer with their Individual Support Plan/ Individualized Family Services Plan/ Person Centered Plan (Planning Team) should determine when goals have been met and the service should be terminated.

b. The individual/responsible person declines the service.

c. The individual moves to another state.

d. The individual requires other more appropriate services.

e. The individual/responsible person now has adequate resources or other support to provide the service.

A Notice of Intended Action must be sent in accordance with the processes defined in Chapter 2200 of this manual.

602.5 Home Health Aide

602.5.1 Service Description and Goals (Home Health Aide)

This service provides intermittent medically necessary health maintenance, continued treatment or monitoring of a health condition and supportive care for activities of daily living at the individual's place of residence. A Home Health Aide serves as an assistant to the primary caregiver, under the supervision of a licensed, registered nurse following a plan of care based upon the individual's medical condition as prescribed by the Primary Care Provider (PCP) and authorized by Health Care Services (HCS).

The goal of this service is to increase or maintain self-sufficiency of eligible individuals.

602.5.2 Service Settings (Home Health Aide)

Home Health Aide services are provided in the individual's home, but are not provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), Nursing Facility (NF) or hospital.

602.5.3 Service Requirements (Home Health Aide)

a. This service shall be supervised by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse. The agency supervisor shall conduct home visits at least every 60 days.

b. The service shall follow a plan of care developed by the supervisor, individual and provider, in accordance with the PCP, which includes monitoring vital signs; changing dressings and/or bandages; care and prevention of bedsores; assistance with catheter (not to include insertion); assistance with bowel, bladder and/or ostomy program; assistance with self-medication; nail and skin care; assistance with personal hygiene; assistance with eating; assistance with ambulation, range of motion and exercise activities; assistance with special appliances and/or prosthetic devices; and transfers to and from wheelchair.

c. The service may include teaching the primary caregiver how to perform the home health tasks contained in the plan of care.

d. The service must be prescribed by a licensed physician as part of a written plan of care that shall be reviewed and recertified by the physician at least every 60 days.

602.5.4 Target Population (Home Health Aide)

This service is indicated for individuals who have a health condition that requires intermittent assistance, as ordered by a physician, which is documented in the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan.

602.5.5 Exclusions (Home Health Aide)

Exclusions to the provision of Home Health Aide services include, but are not limited to:

a. Home Health Aide service shall not be used in place of another, more appropriate service such as Personal Care or Habilitation.

b. Home Health Aides shall not provide skilled nursing services.

602.5.6 Service Provision Guidelines (Home Health Aide)

In addition to requiring a physician's order, a nursing assessment must be completed prior to Home Health Aide service being provided. This assessment may be done by the District Utilization Review Nurse or by a nurse from Health Care Services (HCS). Approval for this service must come from HCS.

602.5.7 Provider Types and Requirements (Home Health Aide)

Designated District staff will ensure all contractual requirements related to Home Health Aide providers are met before services can be provided. Additionally, all providers of Long Term Care Services must be certified by the Division and registered with the Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.5.8 Service Evaluation (Home Health Aide)

a. The physician will review the plan of care at least every 60 days and prescribe continuation of the service.

b. The agency nurse supervisor will review the plan of care at least every 60 days for appropriateness.

c. The provider will submit progress notes on the plan of care on a monthly basis to the Division Support Coordinator.

602.5.9 Service Closure (Home Health Aide)

Service closure should occur in the following situations:

a. Based on the plan of care, it is determined by the physician that the service is no longer needed.

b. The consumer/responsible person declines the service.

c. The consumer moves out of State.

d. The consumer requires other, more appropriate services, e.g., home nursing or personal care.

e. The consumer/responsible person has adequate resources or other support to provide the service.

A Notice of Intended Action must be sent in accordance with the processes defined in Chapter 2200 of this manual.

602.6 Home Nursing

602.6.1 Service Description and Goals (Home Nursing)

This service provides nursing intervention in the consumer's place of residence. Services may include patient care, coordination, facilitation and education.

Home health nursing includes intermittent and continuous nursing services as described in Chapter 1200 of the AHCCCS policy manual (Policy 1240). azahcccs.gov/Regulations/

Intermittent Nursing Services

Intermittent nursing services must be ordered by a physician and provided by a registered nurse or a licensed practical nurse. Skilled nursing assessments are required for monitoring purposes. The service provider must also submit written monthly progress reports to the consumer's primary care provider or attending physician for intermittent nursing services.

Continuous Nursing Services

Continuous nursing services/home health private duty nursing must be ordered by a physician and provided by a registered nurse or a licensed practical nurse in accordance with 42 CFR 440.80 (www.gpoaccess.gov/cfr/). Continuous nursing services may be provided for consumers who are ALTCS eligible and reside in their own home. Continuous nursing services are provided as an alternative to hospitilization or institutionlization when care cannot be safely managed within the scope and standards of intermittent nursing care and when determined to be cost-effective.

The goals of this service are to:

a. Increase or maintain self-sufficiency of eligible individuals.

b. Improve or maintain the physical well-being of eligible individuals.

602.6.2 Service Settings (Home Nursing)

The service shall not be provided in an Intermediate Care Facility (ICF/MR) for the Mentally Retarded, Nursing Facility (NF) or hospital.

602.6.3 Service Requirements (Home Nursing)

Before Home Nursing can be authorized, the following criteria must be met:

a. All consumers receiving this service shall have a nursing assessment done by a Division Nurse to determine skilled intervention, which includes:

1. A review of the current medical files including all pertinent health-related information, to identify potential health needs of the individual related to the Division nursing assessment.

2. Assessment of the health status of the consumer by a review of the current medical data, communication with the consumer, team members and families and assessment of the

consumer in relation to physical, developmental and behavioral dimensions.

3. When home nursing services are identified by the Division Nurse, a referral is submitted to the Division contracted home health nursing providers. The home nursing service provider must obtain an order from the primary care provider to perform duties related to home nursing care.

b. A licensed primary care provider must prescribe the services as a part of a written “plan of care”. This “plan of care” must be reviewed and recertified by the primary care provider at least every 60 days.

c. The service shall follow a written nursing plan of care developed by the Division contracted Home Health provider, in conjunction with The Division's Support Coordinator, the consumer/responsible person and the Division Nurse which includes:

1. Specific services to be provided.

2. Who will provide the specific service.

3. Anticipated frequency and duration of each specific service.

4. Expected outcome of services.

5. Coordination of these services with other services being received or needed by the individual.

6. Input of the consumer/responsible person.

7. Assisting the consumer in increasing independence.

The nursing plan of care shall be included in and reviewed by the Individual Support

Plan/Individualized Family Services Plan/Person Centered Plan team (Planning Team).

602.6.4 Target Population (Home Nursing)

Support Coordinators will identify individuals who potentially need nursing through the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan process (Planning Process) and will submit a referral to the Division Nurse. The Division Nurse upon referral from the Support Coordinator will complete a nursing assessment and if the need is justified, a referral will be made to a contracted Division nursing agency. The contracted Division nursing agency will be responsible to obtain a written order from the primary care provider to perform the duties of home nursing care. The allocation of skilled nursing care hours is determined by the Division Nurse; based on the nursing needs identified on the Division nursing assessment.

602.6.5 Exclusions (Home Nursing)

Exclusions to the provision of Home Nursing include:

a. Nurses may not provide service under physician's orders and prescribed medical procedures that have been changed by someone other than the physician.

b. Nurses may not be paid to provide other services, such as personal care during the time they are providing home nursing.

c. Home nursing shall not be used for day care.

d. Nurses shall not provide direct supervision of non-licensed persons engaged in service provision.

602.6.6 Service Provision Guidelines (Home Nursing)

In addition to requiring a physician's order, a nursing assessment must be completed prior to Home Nursing being provided. The Division Nurse will complete this assessment.

602.6.7 Provider Types and Requirements (Home Nursing)

Designated District staff will ensure all contractual requirements related to Home Nursing are met before services can be provided. Additionally, all providers of Long Term Care Services must be certified by the Division and registered with the Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.6.8 Service Evaluation (Home Nursing)

a. Written assessment shall be completed quarterly by the Division Nurse, maintained on file and a copy sent to the Support Coordinator.

b. The Division contracted home health provider shall complete a nursing care plan and submit a copy to the Division Nurse and the Division Support Coordinator.

c. Each nursing plan of care from the Division contracted home health nursing provider shall be updated at least every 60 days. Any revisions to the plan shall be sent to the Division Nurse and the Divisions Support Coordinator.

d. All physician orders shall be maintained and implementation documented in each individual's file.

e. Any contact made on behalf of the individual shall be documented.

602.6.9 Service Closure (Home Nursing)

Service closure should occur when assessments by the Division Nurse, in conjunction with the Support Coordinator, indicate no further need for skilled nursing.

a. The Division Nurse is to inform the primary care provider that skilled nursing service is no longer required.

b. The Division Nurse is to inform the Division contracted home health provider that skilled nursing service is no longer required. The Division contracted home health provider is to obtain a discharge order from the primary care provider.

In addition to the consumer's home, nursing services may also be provided in group homes, developmental homes, Level I and Level II behavioral health facilities or day treatment and training programs as appropriate.

A Notice of Intended Action must be sent in accordance with the processes defined in Chapter 2200 of this manual.

602.7 Hospice

602.7.1 Service Description and Goals (Hospice)

Hospice services significantly impacts consumers/families served by the Division who are in the process of making end of life decisions. The Division is determined to ensure that the existence of a consumer's disability bears no influence on end of life decisions and is committed to protect the best interest of people with developmental disabilities.

The Division is also determined to ensure that the decision to provide life-sustaining treatment to consumers is determined by using the same standards of judgment used to assess the same decisions regarding persons without developmental disabilities.

The Division is opposed to decision-making to hasten death due to the perception that people with developmental disabilities have a "low quality of life" and believes that the lives of all people are valuable. As a result, the Division is committed to helping consumers obtain the best care possible. The Division also believes that treatment should be conducted in accordance with the consumer's wishes or what is understood to best represent the consumer's best interests.

Situations may arise where the burden of medical treatment outweighs the benefit to the consumer. The Division is aware of situations where consumers, families and health care providers

weigh the benefits of care when there is no hope for improved health and the prolonging of life no longer benefits the "patient."

The Division discourages the removal of life sustaining devices. If the consumer, surrogate, and medical experts determine that life sustaining devices are not in the consumer's best interest, they may determine other options. A consumer's disability should not be a determining factor when considering whether or not to remove life sustaining devices.

First, treatment that provides no discomfort and alleviates pain may be continued. Next, treatment that needlessly prolongs suffering may be eliminated while maintaining those devices that allow for comfort and rest. Finally, all life sustaining devices may be removed in an effort to allow the progression of natural events to take place, unless the cessation of certain devices would cause pain and discomfort.

Division staff confronted with end of life situations should do the following:

a. Share the Division's perspective on the lives of consumers.

b. Emphasize that the consumer's disabilities should not influence medical decisions.

c. Encourage cooperation, and open communication to determine the consumer's best interest with family members, surrogate decision makers, and health care providers.

d. When a consumer has an advanced directive, durable power of attorney, health care directive power of attorney, or any such legal document, the Division respects the consumer's lawful wishes as specified in the legal document.

e. If there is no such legal document providing guidance in end of life situations the following need to be considered;

1. The consumer's ability to participate in the activities and functions that provide pleasure and value to their lives.

2. The consumer's health condition.

3. The benefit of treatment.

4. Treatment options.

5. The consumers best interest.

Hospice services are provided to Arizona Long Term Care System (ALTCS) members who meet medical criteria/requirements and are not based on a person's disability. Hospice services provide palliative and support care for terminally ill members and their family or caregivers. Hospice services provide health care and emotional support for terminally ill individuals and their families/caregivers during the final stages of life.

602.8 Housekeeping

602.8.1 Service Description and Goals (Housekeeping)

This service provides assistance in the performance of activities related to routine household maintenance at a consumer's residence. The goal of this service is to increase or maintain a safe, sanitary and/or healthy environment for eligible individuals.

602.8.2 Service Settings (Housekeeping)

This service would occur in the individual's own home or family's home. It would occur outside only when unsafe/unsanitary conditions exist and would occur in the community when purchasing supplies or medicines.

602.8.3 Service Requirements (Housekeeping)

Before Housekeeping can be authorized, the following requirements must be met:

a. Safe and sanitary living conditions shall be maintained only for the consumer's personal space or

common areas of the home the consumer shares/uses.

b. Tasks may include:

1. Dusting.

2. Cleaning floors.

3. Cleaning bathrooms.

4. Cleaning windows (if necessary to attain safe or sanitary living conditions).

5. Cleaning oven and refrigerator (if necessary to prepare food safely).

6. Cleaning kitchen.

7. Washing dishes.

8. Changing linens and making beds.

9. Routine maintenance of household appliances.

c. Washing, drying and folding the consumer's laundry (ironing only if the consumer's clothes cannot be worn otherwise).

d. Shopping for and storing household supplies and medicines.

e. Unusual circumstances may require the following tasks be performed:

1. Tasks performed to attain safe living conditions:

– Heavy cleaning such as washing walls or ceilings.

– Yard work such as cleaning the yard and hauling away debris.

2. Assist the individual in obtaining and/or caring for basic material needs for water heating and food by:

   – Hauling water for household use.

   – Gathering and hauling firewood for household heating or cooking including sawing logs and chopping wood into usable sizes.

   – Caring for livestock used for consumption including feeding, watering and milking.

3. Provide or insure nutritional maintenance for the consumer by planning, shopping, storing and cooking foods for nutritious meals.

602.8.4 Target Population (Housekeeping)

Consumers who are eligible for or are receiving assistance through the Supplemental Payment Program (SPP) will not receive Housekeeping. consumers who are not eligible for Long Term Care Services should be referred to the SPP. Needs are assessed by the Support Coordinator based upon what is normally expected to be provided by an individual and/or his/her caregiver. It is important to remember that housekeeping services are based on “assessed need” and not on a person’s or the family’s stated desires regarding specific services. Consideration should be made to age appropriate expectations of the consumer and his/her entire family (what can reasonably be expected of each consumer based on his/her age). The team should consider the natural supports are available and not supplant them. In addition to the guidelines found in section 602, there may be a need for the SPP if any of the following are factors:

a. A consumer is living with his/her family and has intense medical, physical or behavioral needs and the family members are unable to care for the individual and maintain a safe and sanitary environment.

b. A consumer is living with his/her family and the family members have their own medical/physical needs that prevent the family members from maintaining a safe and sanitary environment (documentation of the medical/physical needs may be required).

c. A consumer is living independently and has medical/physical needs that preclude him/her from maintaining/attaining a safe and sanitary environment.

d. A consumer is living independently and has demonstrated that he/she cannot maintain a safe and sanitary environment. Habilitation should be considered before using Housekeeping so the consumer's abilities may be maximized.

e. The family is experiencing a crisis that prevents them from maintaining a safe and sanitary environment. The situation would be documented in the consumer's progress notes and the service delivery would be of a time-limited nature.

602.8.5 Exclusions (Housekeeping)

The following exclusions apply to the provision of Housekeeping:

a. Housekeeping is to be performed only for the consumer's areas of the home or common areas of the home used by the consumer, i.e., parents' or sibling's bedrooms or bathrooms would not be cleaned. Other examples of inappropriate use of Housekeeping services include:

1. Cleaning up after parties.

2. Cleaning up several days of accumulated dishes.

3. Preparing meals for the whole family.

4. Routine lawn care.

b. Housekeeping shall not be provided to consumers residing in group homes, vendor supported developmental homes, skilled nursing facilities, non-state operated Intermediate Care Facilities for the Mentally Retarded or Level I or Level II behavioral health facilities.

602.8.6 Service Provision Guidelines (Housekeeping)

Typical utilization of Housekeeping would be 2 - 4 hours per week. Additionally:

a. The consumer or family is expected to provide all necessary supplies.

b. This service shall not be provided when the consumer is hospitalized or otherwise receiving institutional services. The service may only be provided at the end of hospitalization to allow the individual to return to a safe and sanitary environment.

c. Consumers residing in group homes, foster homes or adult developmental homes shall not receive this service.

Utilization of housekeeping will be in accordance with the Service Authorization Matrix.

602.8.7 Provider Types and Requirements (Housekeeping)

Designated District staff will ensure all contractual requirements related to Housekeeping providers are met before services can be provided. Additionally, all providers of Long Term Care Services must be certified by the Division and registered with Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.8.8 Service Evaluation (Housekeeping)

The Individual Support Plan/Individualized Family Service Plan/Person Centered Plan review (Plan Review) shall document appropriateness of this service based upon the Support

Coordinator's observation and input from the consumer, family and provider.

602.8.9 Service Closure (Housekeeping)

This service is no longer appropriate when:

a. The consumer's medical, physical or behavioral needs have decreased.

b. The physical/medical needs of the family members have decreased.

c. The family is no longer experiencing crisis.

d. The consumer no longer resides at home, has moved out of State or when the consumer is no longer eligible for Long Term Care Services (refer to the Supplemental Payment Program)

e. The consumer moves to a residential or institutional setting.

f. The family has adequate resources or other support to provide the service.

A Notice of Intended Action must be sent in accordance with the processes defined in Chapter 2200 of this manual.

602.8.10 Other Housekeeping Services

a. The amount of Housekeeping provided shall be determined based on the home requirements for a safe and sanitary environment. If more than one eligible consumer resides in the home, payment will not be made twice for cleaning common areas of the home.

b. If the family is receiving supplemental payments for other individuals in the home, the Support Coordinator shall determine if the Supplemental Payment Program (SPP) is meeting the family's needs.

602.9 Intermediate Care Facilities For The Mentally Retarded

602.9.1 Service Description and Goals Intermediate Care Facility for the Mentally Retarded

This service provides health and habilitative services to consumers with developmental disabilities.

The goal of this service is to provide an environment in which the programmatic and habilitative needs of eligible persons are met through an active treatment process.

A continuous active treatment program includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward the acquisition of the behaviors necessary for the consumer to function with as much self determination as possible; and the prevention or deceleration of regression or loss of current optimal functional status. Active treatment does not include services to maintain generally independent consumers who are able to function with little supervision or in the absence of a continuous active treatment program.

602.9.2 Service Settings Intermediate Care Facility for the Mentally Retarded

Intermediate Care Facilities for the Mentally Retarded (ICF/MR) shall only include the Arizona training program facilities, a State owned and operated service center, State owned or operated residential settings or existing licensed facilities operated by the State or under contract with the Department on or before July 1, 1988.

A.R.S. § 36-2939(B)(1) azleg.gov/ArizonaRevisedStatutes.asp

602.9.3 Service/Provider Requirements Intermediate Care Facility for the Mentally Retarded

a. The Intermediate Care Facility for the Mentally Retarded (ICF/MR) shall be reviewed annually by the Department of Health Services and certified by

Arizona Health Care Cost Containment System (AHCCCS) or pursuing certification.

b. The ICF/MR shall be licensed, certified and monitored in accordance with A.R.S. § 36-591(G). azleg.gov/ArizonaRevisedStatutes.asp

c. The ICF/MR shall comply with the conditions set forth in Chapter 42 of the Code of Federal Regulations. www.gpoaccess.gov/cfr/

d. The ICF/MR shall comply with A.A.C. R6-6-901 through R6-6-910 (Article 9) Managing Inappropriate Behaviors. azsos.gov/public_services/rules.htm

e. A Cost Effectiveness Study (CES) shall be completed prior to admission or discharge from an ICF/MR (Appendix 600.D).

602.9.4 Target Population Intermediate Care Facility for the Mentally Retarded

a. Health Care Services requires review and revision of the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) prior to any permanent/temporary admission to a private ICF/MR. The Support Coordinator shall forward the Planning Documents to Health Care Services (HCS). The written authorization of the Assistant Director shall be required prior to placement.

b. Prior to considering a permanent/temporary placement in a state operated ICF/MR, the Division Support Coordinator shall exhaust all other placement options (including private ICF/MR and written approval by the Assistant Director is required.

602.9.5 Exclusions Intermediate Care Facility for the Mentally Retarded

ICF/MR placements shall not be made when appropriate, cost effective services are available in the community.

602.9.6 Service Provision Guidelines Intermediate Care Facility for the Mentally Retarded

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602.9.7 Service Evaluation Intermediate Care Facility for the Mentally Retarded

The provider shall comply with the conditions set forth in Chapter 42 of the Code of Federal Regulations (www.gpoaccess.gov/cfr/). In addition to certification reviews by Department of Health Services, the Division's Quality Assurance Unit will do "Continued Stay Reviews" and "Active Treatment Reviews".

602.9.8 Service Closure Intermediate Care Facility for the Mentally Retarded

The consumer shall be discharged from the Intermediate Care Facility for the Mentally Retarded (ICF/MR), as appropriate, in accordance with the following:

a. A new Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Document) and Cost Effectiveness Study (Appendix 600.D) shall be completed prior to the anticipated discharge, at least 10 days in advance, except in those cases where the discharge is of short duration, i.e., 5 days or less.

b. A discharge plan shall be developed including the participation of the consumer and all Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team (Planning Team) members and the discharge plan shall take precedence. The consumer/responsible person, the Primary Care Provider (PCP), the attending Physician and the Division's Medical Director shall resolve disagreements when there are differences between the Planning Documents and the discharge plan. The Medical Director shall have the final authority as delegated by the Assistant Director.

c. The consumer's PCP shall be given the opportunity to participate in the Individual Support Plan/Individualized Family Services Plan/ Person Centered Plan meeting (Planning Meeting) and to review the respective documents.

d. The District Utilization Review Nurse shall participate in the Planning Meetings. The nurse shall ensure the discharge planning process has been completed and shall certify concurrence with the plan by signing these documents.

e. The District Program Manager/District Program Administrator (DPM/DPA) shall certify concurrence by signing the discharge plan.

f. The discharge plan, with the required signatures, shall be forwarded to the Division's Health Care Services (HCS) and Medical Director for final review and certification.

g. The completed discharge package shall be returned to the DPM/DPA for implementation of the plan.

The entire process above shall be completed before the discharge is made.

A Notice of Intended Action must be sent in accordance with the processes defined in Chapter 2200 of this manual.

602.10 Nursing Facility

602.10.1 Service Description and Goals (Nursing Facility)

This service provides skilled nursing care, residential care and supervision to persons who need nursing services on a 24-hour basis, but who do not require hospital care under the daily direction of a physician.

The goal of this service is to provide an environment that meets and enhances the medical, physical and emotional needs of individuals residing in nursing facilities.

602.10.2 Service Settings (Nursing Facility)

Nursing facilities must be Medicare and Medicaid certified unless not available in the community. For the purposes of reimbursement by Arizona Long Term Care System (ALTCS) funding, the facility must be Medicaid certified.

602.10.3 Service/Provider Requirements (Nursing Facility)

Designated District staff must ensure the following are met before service is initiated:

a. The nursing facility (NF) must be licensed and certified by the appropriate Arizona State agencies and comply with all applicable federal and state laws relating to professional conditions, standards and requirements for NF(s).

b. The NF must also comply with all health, safety and physical plant requirements established by federal and state laws.

c. The Contractor must be registered with Arizona Health Care Cost Containment System (AHCCCS) to provide this service for that portion of the facility subject to Medicaid reimbursement.

602.10.4 Target Population (Nursing Facility)

Individuals in need of skilled nursing care on a 24-hour basis may be considered appropriate for this service. Prior to admission, the individual must be screened in accordance with federal law (see Section 700 – Pre-Admission Screening/Annual Resident Review) and reviewed for appropriateness of placement whenever a significant change in the physical or mental status of the individual occurs.

602.10.5 Exclusions (Nursing Facility)

Long Term Care Services may be provided only in Medicare and Medicaid certified NF(s). State funded services do not need to be provided in Medicare or Medicaid certified facilities. No payments may be made for inappropriate placements pursuant to Chapter

42 Code of Federal Regulations 456.1 (www.gpoaccess.gov/cfr/ , see also Section 700 – Pre-Admission Screening/Annual Resident Review).

The Arizona Health Care Cost Containment System (AHCCCS) will advise the Division when a NF is placed on termination status due to noncompliance with Medicaid/Medicare participation requirements. No new admissions can be made to a Nursing on termination status.

Consumers currently residing in or on leave from a NF placed on termination status may remain in or return to the facility, if each individual's Primary Care Provider (PCP) agrees with the District Utilization Review Nurse's assessment that the NF can continue to meet the needs of the individual.

If the PCP or District Utilization Review Nurse does not feel the NF can meet the individual's needs, the individual must be offered a choice of available alternatives to include home and community based services.

602.10.6 Service Provision Guidelines (Nursing Facility)

In addition to requiring a physician's order, a nursing assessment must be completed prior to NF Services being provided. This assessment will be done through the Pre-Admission Screening/Annual Resident Review (PASRR) process.

602.10.7 Service Evaluation (Nursing Facility)

Consumers residing in NF(s) must be reviewed when there is a significant change in the physical or mental condition of the consumer (see Section 707 – Pre-Admission Screening/ Annual Resident Review) in addition to the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process (Planning Process). Physicians shall certify the need for nursing facility placement in accordance with Chapter 42 Code of Federal Regulations. www.gpoaccess.gov/cfr/

602.10.8 Service Closure (Nursing Facility)

Nursing Facility services will be terminated when there is no longer a need for 24-hour skilled nursing care, as determined by the Individual Support Plan/Individualized Family Support Plan/Person Centered Plan (Planning Document/Meeting) and the physician following the Pre-Admission Screening/Annual Resident Review (PASRR) recommendations. The discharge shall occur as follows:

a. A new Planning Document shall be completed prior to the anticipated discharge at least 10 days in advance except in those cases where discharge is of short duration, i.e., 5 days or less.

b. The discharge plan shall be the document through which the discharge of the individual is managed. All members of the Individual Support Plan/ Individualized Family Services Plan/Person Centered Plan team (Planning Team) shall be involved in the discharge planning process and the discharge plan shall take precedence. The individual or responsible person, the Primary Care Provider (PCP), attending Physician and the Division's Medical Director shall resolve disagreements regarding discharge planning.

c. The consumer's PCP shall be given the opportunity to participate in the Planning Meetings and to review the respective Planning Documents.

d. The District Utilization Review Nurse shall participate in the Planning Meetings. The District Utilization Review Nurse must also ensure discharge planning has been completed by signing these respective documents.

e. The Division's District Program Manager/District Program Administrator (DPM/DPA) signature is also required on the discharge plan.

f. The discharge plan with the required signatures shall be forwarded to the Division's Medical Services Manager.

g. Health Care Services (HCS) and the Division's Medical Director shall conduct the final review.

h. The complete discharge package shall be returned to the District Program Manager/District Program Administrator for implementation of the plan (DPM/DPA).

A Notice of Intended Action must be sent in accordance with the processes defined in Chapter 2200 of this manual.

602.11 Respite

602.11.1 Service Description and Goals (Respite)

This service provides short-term care to relieve caregivers. Individuals who are cared for by respite providers must be eligible for supports and services through the Division. Respite Providers may be required to be available on a 24-hour basis. Respite services are intended to temporarily relieve unpaid caregivers. Respite services are not intended as a permanent solution for placement or care. The number of hours authorized for respite services must be used for respite services and cannot be transferred to another service.

602.11.2 Service Settings (Respite)

Respite may be provided in the following settings:

a. The consumer's home.

b. A Medicare/Medicaid certified Nursing Facility.

c. A group home, foster home or adult developmental home certified by the Division.

d. A certified Intermediate Care Facility for the Mentally Retarded (ICF/MR).

e. An individual provider's home that comply with the requirements of the Department of Health Services or the Division.

602.11.3 Service Requirements (Respite)

Before Respite can be authorized, the following requirements must be met:

a. Prior to initiating service, the provider shall meet with the primary caregiver to obtain necessary information regarding the consumer including obtaining a notarized medical consent if the caregiver will not be immediately accessible.

b. The provider shall:

1. Supervise the consumer and meet their social, emotional and physical needs.

2. Ensure the consumer receives all prescribed medications in the ordered dose and time.

3. Administer First Aid and give appropriate attention to injury or illness.

4. Supply food to meet daily nutritional needs including any prescribed therapeutic diets.

5. Furnish transportation as needed to day programs and appointments.

6. Carry out any programs as requested by the Planning Team.

7. Report any unusual incidents to the Division in accordance with policies and procedures.

. 8. Ensure appropriate consideration of consumer needs, compatibility and safety when caring for unrelated individuals.

602.11.4 Target Population (Respite)

Respite, as a medically related social service is appropriate based upon family needs, as written in the Individual Support Plan/Individualized Family Support Plan/Person Centered Plan (Planning Documents). Respite services are also appropriate based on the following factors:

a. The primary caregiver is unable to obtain respite and other supports from his/her immediate/extended family or from other community resources.

b. The primary caregiver needs time to recover from abnormally stressful situations in order to resume his/her responsibilities.

c. The consumer with a developmental disability presents intense behavioral challenges or needs a high degree of medical care.

d. The primary caregiver is experiencing an emergency that temporarily prevents performance of normal responsibilities.

e. The primary caregiver requires more frequent or extended relief from care responsibilities due to advanced age or disability.

f. The family is experiencing unusual stressors such as care for more than one person who has a developmental disability.

g. Respite services can only be provided for children ages 0 to 3 related to required training for the primary caregiver. This training requirement must be documented in the Individualized Family Services Plan (IFSP).

602.11.5 Exclusions (Respite)

Exclusions to the provision of Respite services may include the following:

a. Respite shall not substitute for routine transportation, day care or another specific service.

b. Respite shall not substitute for a residential placement.

c. Respite providers shall not serve more than three (3) people at one time.

d. Foster care (child developmental homes) and adult developmental home providers shall not give services to more individuals than would exceed their Division license.

e. Foster care (child developmental homes) and adult developmental home respite providers shall not give services to children and adults simultaneously. This is only allowed if stated on the license. Additionally, the provider shall not offer services to adults if the license is for children and vice versa.

f. Respite is not available for consumers living in group homes or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

g. Assisted Living Centers, non-state operated Intermediate Care Facilities for the Mentally Retarded, skilled nursing facilities, Level I or Level II behavioral health facilities and consumers living independently are not approved for respite.

602.11.6 Service Provision Guidelines (Respite)

a. The federal government and the Arizona Heath Care Cost Containment System (AHCCCS) sets the upper limit of 720 hours per year regarding respite services for individuals who are eligible for Long Term Care. Respite Service hours are determined on a yearly

basis by the initial Individual Support Plan/ Individualized Family Services Plan/Person Centered Plan process and periodic review of these documents.

b. Individuals who are eligible for respite services funded by the state are subject to the availability of these funds. The continuation of respite services is determined on a yearly basis through the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and periodic review of these documents. Respite services are intended to allow unpaid primary care givers a break and, as such, the assessment for respite hours will need to be reconciled with the amount of time an unpaid primary caregiver usually provides support.

c. All hours of respite utilized by the consumer/family will be tracked and reported. Respite hours for individuals who are eligible for Long Term Care Service will be reported to AHCCCS.

d. A service unit of one (1) hour will be authorized for short- term respite up to thirteen (13) continuous hours in a calendar day. A service unit of one (1) day will be authorized for extended respite of more than thirteen (13) continuous hours in a calendar day. A provider for short-term respite will bill the actual hours provided. A provider will bill for extended respite for the appropriate number of days of service. This billing for extended respite will also include the cumulative hours of service provided on the Uniform Billing Document.

e. A negotiated rate will be applied for families who have more than one person eligible for respite. This negotiated rate will be reported by the provider, with the total actual hours of service given to each individual on the Uniform Billing Document. This method of rate setting will be applied when these individuals receive respite at the same time. The

hours used will be deducted by the Division from the authorized level of respite for each person.

f. Families receiving respite for an individual eligible for services from the Division who wish other non-eligible individuals to receive care will be responsible for the costs of serving the non-eligible individual. The Division will only pay for services delivered to individuals authorized to receive such service and will pay the provider at a multiple client rate.

602.11.7 Provider Types and Requirements (Respite)

Designated District staff will ensure all contractual requirements related to Respite providers are met before service can be provided. Additionally, all providers of Long Term Care Services must be certified by the Division and registered with Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.11.8 Service Evaluation (Respite)

The Support Coordinator must continually assess the quality of the services provided to consumers with developmental disabilities in accordance with the mission statement. Additionally:

a. The provider shall submit attendance reports summarizing the consumers served and the number of hours of service to the designated District representative. All incidents shall be reported to the Division within the required timelines.

b. The Support Coordinator and the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team (Planning Team) shall determine the on-going appropriateness of the service based upon the input from the providers and the individual's caregiver(s).

602.11.9 Service Closure (Respite)

a. Respite shall terminate when the consumer begins to live independently or in a Group Home, Vendor Supported Developmental Homes or, Intermediate Care Facility for the Mentally Retarded ICF/MR or Nursing Facility (NF).

b. Respite shall terminate when the family no longer desires the service.

c. Respite for consumers who are eligible for services through the Arizona Long Term Care System (ALTCS) shall terminate when the maximum amount allowed has been used and there are no State funds available.

A Notice of Intended Action must be sent in accordance with the processes defined in Chapter 2200 of this manual.

602.12 Room and Board

602.12.1 Service Description and Goals (Room and Board)

This service provides for a safe and healthy living environment on a 24-hour basis that meets the physical and emotional needs of an individual.

602.12.2 Service Settings (Room and Board)

Room and board may be provided in any State operated or contracted community residential setting.

602.12.3 Service Requirements (Room and Board)

Before Room and Board can be authorized, the following requirements must be met:

a. Living arrangements for individuals served must be identified

b. Nutritional maintenance for individuals served must be ensured and provided.

602.12.4 Target Population (Room and Board)

All individuals receiving services in a residential setting may also receive room and board.

602.12.5 Exclusions (Room and Board)

Exclusions to the provision of Room and Board include Home and Community Based Services. Other room and board services excluded are those funded by Arizona Long Term Care System (ALTCS). All other fund sources shall be exhausted prior to funding by the Division.

602.12.6 Service Provision Guidelines (Room and Board)

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602.12.7 Provider Types and Requirements (Room and Board)

Designated District staff will ensure all contractual requirements are met before Room and Board is provided.

602.12.8 Service Evaluation (Room and Board)

The provider shall maintain an on-site file that documents appropriate inspections and licenses necessary to operate the home.

602.12.9 Service Closure (Room and Board)

This service shall be terminated when an individual moves from a State operated or contracted residential setting.

A Notice of Intended Action must be sent in accordance with the processes defined in Chapter 2200 of this manual.

602.13 Therapies – Occupational, Physical and Speech

Individuals with special needs sometimes require assistance to achieve functional skills. Therapy is one method among many to accomplish the functional outcomes/goals identified by people with developmental disabilities and their families through the team planning process.

The Individual Support Plan/Individual Family Services Plan/Person Centered Plan process supports consumer driven outcomes. It is important to allow the consumer to direct the path of therapeutic interventions by addressing their resources, priorities concerns, and cultural values.

Recommendations made by a therapist should be reviewed by the Planning Team and included in the Planning Documents. There should not be a separate therapy plan or separate planning process.

The direction and oversight of a therapist is a valuable resource that must be effectively utilized to achieve maximum benefit. There must be a shared effort between the therapist and the consumer family/caregiver, providers, teachers, doctors and others.

The therapist must:

a. Participate as part of the planning team.

b. Complete an evaluation to assess the individual's needs.

c. Recommend integrated, functional activities.

d. Instruct individuals and/or caregivers to incorporate these activities into the individual's routines.

e. Oversee implementation and progress.

f. Provide direct therapy when necessary and appropriate.

The role of the consumer/family/caregiver is to carry out the functional activities recommended by the therapist frequently throughout the day by incorporating them into the natural routine of the individual and family.

The need for therapy may vary throughout the consumer's lifetime and is related to periodic life and skill changes. Therapeutic intervention must be dynamic and flexible enough to accommodate these changes.

602.13.1 Service Description and Goals (Therapies)

This service directs the consumer's participation in selected activities to maintain or improve functional skills. This service requires a medical prescription for consumers who are eligible for Long Term Care Services and must be provided by licensed or certified therapists.

The goal of this service is to improve the consumer's functional capabilities and physical wellbeing.

602.13.2 Service Provision Guidelines (Therapies)

Therapies shall be delivered according to the consultation/ coaching model in a natural environment. The therapist will make every effort to provide services with a family member, caretaker or designee to be present. In circumstances that the service is delivered in a clinic setting the same applies or other personnel may be present in the same clinic. This is not applicable to adults who are their own guardians.

a. The team responsibilities for therapy implementation include:

1. The consumer/family and others as part of the Planning Team (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team) identifies specific needs or areas of potential need.

2. The Support Coordinator completes an authorization form, including insurance information, for needed services.

3. The Support Coordinator or other person, as identified in the Individual Support Plan/ Individualized Family Services Plan/Person Centered Plan (Planning Documents), obtains a prescription for consumers who are eligible for Long Term Services from the Primary Care Provider (PCP).

4. The therapist completes assessments and develops a plan of meaningful activities incorporated into the individual's naturally occurring routines in collaboration with other involved service providers and agencies.

5. The Planning Team identifies resources, priorities and concerns and develops outcomes for the individual. The planning team also discusses strategies for meeting the identified outcomes. Additionally, the Planning Team reviews and approves the plan's continuation.

6. The family works with the Support Coordinator and therapist to provide and update insurance information for billing purposes.

7. The therapist trains the consumer/family and other caregivers, assists and oversees implementation of the plan and documents progress.

8. Hands-on (direct) treatment by a therapist will be short-term and outcome driven. The therapy will also be consultative in nature.

b. The components of therapy services include:

1. Therapy assessment/re-assessment.

The Planning Team reviews available documentation to determine the need for an assessment or reassessment.

The request for a therapy assessment or reassessment is directly related to a desired functional skill and outcome as identified by the Planning Team.

The assessment is the first step in the support and intervention process and addresses the consumer/family resources, priorities and

concerns needs. The consumer/family should be an active participant in the assessment process. They should also make this process positive and helpful.

The assessment or reassessment should define, describe and interpret the consumer's current functional levels and related concerns. Assessments and re-assessments are used to recommend the parameters of therapy. These processes are also used to recommend therapeutic activity, the duration and frequency of the service and the general prognosis. Recommendations regarding the prognosis should address outcomes for the consumer with or without therapeutic intervention. Team consensus is required to determine the level of therapy support as well as specific components to be included in the Individual Support Plan/ Individualized Family Service Plan/Person Centered Plan (Planning Documents).

The Planning Team may authorize re-assessments only when there has been a lapse of the therapy services for six (6) months or more. Treatment sessions should be utilized for standardized testing when needed. Additional sessions, time or units will not be authorized. Evaluations and re-evaluations will not be authorized when on-going treatment is in place.

2. Therapy functional activities.

A consumer's success and benefit from therapy is dependent upon the involvement by the consumer/family and other caregivers with the therapists recommended daily activities. There are frequently and naturally occurring opportunities to use and practice these activities throughout each day. The therapists will support the consumer/family in identifying

activities that can be incorporated into daily routines, support the goals and outcomes that have been established in the respective Planning Documents and utilize the resources of the environment. All persons involved in the consumer's life need to be aware of the recommended activities and receive training to perform these activities. Training may include direct instruction, videotapes, published written materials or other instructional materials.

3. Therapy sessions.

   Therapy sessions should be delivered in a setting that is most beneficial to the consumer and is the choice of the individual and family. All services for children birth to three (3) must be provided in a natural environment. Treatment/consultation must be conducted with the family and caregivers. In addition, family members and caregivers must be present to interact, ask questions and learn from the therapy provider. The therapist will consult with the team and discuss the strategies for implementation by the therapist only. The therapist will also discuss with other team members the transition implementation plan. The transition of therapy sessions will go to other team members. The therapist will implement the strategies to support the outcomes. Each session should be a learning experience and allow opportunities for caregivers to demonstrate their ability to implement the recommended activities.

4. Models of service delivery.

   Models of therapy service delivery will be discussed and agreed upon by the team.

   The frequency, length of sessions and duration of therapist contacts vary greatly depending on

the identified needs, concerns, priorities and resources of the consumer/family and approved by the team.

a. Consultation

The therapist will facilitate, coach and share knowledge with family/caregivers who are in the most optimum position to offer frequent opportunities within the daily routines of the child or adult. Coaching is "learner focused" treatment that moves the focus of the treatment off the child or adult's disability and emphasizes supporting those family/caregivers involved in the child or adult's development.

b. Co-therapy.

Co-therapy occurs when two or more therapists simultaneously evaluate, assess and work with one consumer. This model is used for specific assessment and treatment purposes. This model is only appropriate for some consumers.

Co-therapy shall be time limited and reviewed by the team every three (3) months.

c. Group therapy.

Group therapy occurs when more than one individual receives therapy from one therapist during a single session. This model is used for treatment purposes and is time limited. The team reviews the receipt of Group therapy every three months. Group therapy is only appropriate for some individuals and

should be approved by the team prior to service delivery.

d. Individual therapy.

Direct therapy is a service provided by one therapist for one consumer. Therapy should be outcome driven, time limited and reviewed/approved by the team on an on-going basis.

602.13.3 Exclusions (Therapies)

a. Rehabilitative therapy.

Rehabilitation is the process of restoring former functions or skills due to an accident, illness or surgery.

Funding for all rehabilitative therapy must be sought from the consumer's health plan. This may include private insurance, Children Rehabilitation Services (CRS), Indian Health Services (IHS), Comprehensive Medical and Dental Program (CMDP) and the Arizona Health Care Cost Containment System (AHCCCS). The Division's contracted health plans for consumers who are eligible for the Arizona Long Term Care System (ALTCS) may also fund rehabilitative services. The Division is the payor of last resort.

If a consumer is receiving acute (rehabilitative) and Division medically necessary therapy, services coordination should occur to prevent duplication of services. Teams will collaborate to discuss outcomes and strategies. Prescriptions need to be obtained for both services providers.

b. Therapy necessary for educational purposes.

Public education authorities are responsible for educationally necessary therapy as identified by the child's Individual Education Plan (IEP). During

summer months, these services should be provided by the public education authority extended school year program. The Division cannot authorize or fund therapy to replace or support educationally necessary therapy.

602.13.4 Service Utilization Guidelines

Therapies shall be delivered according to the consultation/ coaching model in a natural environment. The therapist will make every effort to provide services with a family member, caretaker or designee to be present. In circumstances that the service is delivered in a clinic setting the same applies or other personnel may be present in the same clinic. This is not applicable for adult consumers who are their own guardians.

Therapist shall not provide services to the consumer or otherwise have direct contact unless the consumer's parent or caregiver is in the immediate proximity and capable of observing the therapist's actions and behavior.

602.13.5 Reporting Requirements (Therapies)

a. Assessment and re-assessment reports shall include:

1. A review of pertinent medical, educational and therapy reports.

2. The functional activities for family and other caregivers.

3. The functional goals and outcomes that are measurable and time limited.

4. Language that is understandable and useful for other therapists.

5. Written language that is understandable and useful for consumers, families, other caregivers and Support Coordinators.

6. Recommend the model of service delivery and any monitoring or oversight that may be

needed. The model and monitoring must be reviewed and agreed upon by the team with District oversight.

7. Information that identifies and addresses the consumer's/family's resources, priorities and concerns.

8. Information that identifies limitations of the assessment, e.g., questions of rapport, cultural bias and sensory/response requirements.

9. Documents regarding the administration of assessment tools, informal assessments, test scores, explanations of these tools and clinical impressions.

10. As per the Qualified Vendor agreement, assessment reports shall be provided within three (3) weeks of the initial observation/testing to the Support Coordinator, Primary Care Provider and family. Results of the evaluation must be shared with the team prior to the onset of on-going treatment.

b. Contact notes for each session shall be maintained in the therapist's file and submitted to the Division as requested.

c. Quarterly progress reports for each therapy discipline will be submitted to the Support Coordinator, Primary Care Provider (PCP) and consumer/family within 15 days of the end of each three (3) month period following initiation of therapy. Progress reports must be received prior to re-authorization of continued services. The team uses the quarterly progress reports to reassess the therapeutic plan, goals and outcomes. Progress is measure by evaluating whether or not the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan goals have been met. The quarterly progress report shall include:

1. Current frequency, model of service delivery and documentation of attendance.

2. A description of the individual's current level of functioning.

3. A summary of progress toward achieving Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) goals and outcomes.

4. A summary review of consultation, collaboration and coordination with consumers/family/caregivers and other professionals.

5. Information that delineates activities completed only by the therapist from activities completed by family and other caregivers.

6. Recommendations for future needs, levels and model of service delivery.

7. Recommendations for therapy equipment or durable medical equipment including the purpose of the equipment and specific ordering information.

8. A written summary of functional activities for consumers/family and caregivers. Information for therapy or durable medical equipment shall contain instructional materials used, including videotapes, journal articles and individualized instructions.

d. A final report shall be completed at the time of closure or transfer from a service or provider. The report shall summarize information from the quarterly reports, reasons for closure or transfer and the current functioning status for goals and outcomes identified in the Planning Documents. Closure reports shall be submitted to the individual's Support

Coordinator, Primary Care Provider (PCP) and consumer or family within three (3) weeks of the final therapy session.

e. Dates of service documentation must be maintained by all therapists or providers in accordance with the qualified vendor agreement and are subject to audit. Records should be kept in such a way as to document any co-therapy group therapy, individual therapy and/or consultation.

602.13.6. Billable Units (Therapies)

Billable units for therapy services include:

a. Initial assessment.

Up to three (3) hours/units of services for an initial assessment shall be approved upon authorization per the Division published rates schedule. The evaluation/assessment rate includes time for travel contact and documentation. Reporting and writing time shall be included in the billing regarding documentation. However, current evaluations and assessments from other sources must be reviewed and utilized.

Evaluation/assessments will be authorized initially or when there has been a lapse of therapy service for twelve (12) months or more. Evaluations/ assessments must be approved by the Planning Team and written into the document.

One evaluation is billed as one unit of service.

b. Evaluation/Re-assessment.

Re-evaluations/reassessments will be authorized only when there has been a lapse of the therapy service for (6) six months or more. Re-evaluations/re-assessments must be approved by the Planning Team (Individual Support Plan/Individual Family

Services Plan/Person Centered Plan team) and be written into the document.

Treatment sessions should be utilized for standardized testing when needed. Additional sessions/time/units will not be authorized when on-going treatment is in place.

Re-evaluations/re-assessments will be authorized and paid at a lower "evaluation rate" as there is not as much time involved.

c. Attendance at Team Meetings.

Therapist shall make every effort to attend team meetings (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan meetings) and/or Individual Education Plan (IEP) meetings. Team/IEP meeting time will be utilized in lieu of treatment sessions. If the individual has private insurance, a waiver must be requested from the "Benefits Coordinator" as insurance cannot be billed for team meeting time.

d. Contact sessions.

Portions of an hour/unit must be billed when services are less than the full hour/unit. Time spent consulting, is considered part of the session. Contact sessions may also be used for collaboration with other professionals regarding the individual's program.

e. Co-therapy.

Each therapist may bill only for the portion of the hour/unit spent with the individual. .

At the Individualized Family Services Plan team if co-treatment is recommended and placed into the plan this should not require additional authorization. Frequency and duration of co-therapy as pertinent to

meeting the priority and concerns of the family shall be documented. If more then two (2) co-treatments are done in a quarter this will require further authorization from the Division upon justification. Each therapist may bill only for the portion of the hour/unit spent with the individual.

f. Group therapy.

Each therapist shall bill according to the Division published rate schedule for each consumer. The maximum number of participants in group therapy is three (3) individuals per therapist.

g. Quarterly progress reports.

The time used regarding quarterly reports is included in the rates and cannot be charged separately.

h. No-shows and cancellations.

When a therapist travels to an appointment and the consumer is not there or not available for the scheduled session, a no-show may be billed for .5 of the treatment rate. "No shows" and cancellations may be filled for one half hour/unit as long as the time is used on the consumer with less than 24 hours notice. Telephone calls and documentation need to be made. Two "no shows" or cancellations or a pattern of such shall be reported to the Support Coordinator.

The Division will not pay for "no-shows"/absences/ cancellations for group therapy, therapy assessments/evaluations or reassessments/ evaluations, regardless of notification.

"No-shows"/absences/cancellations for treatment sessions, located in an office, center or clinic will NOT be paid regardless of notification.

"No shows"/absences/cancellations for group therapy shall NOT be billed.

i. Private health insurance.

All private health insurance must be billed first as the Division is the payor of last resort. The Division will not pay for insurance billing time.

602.13.7 Statewide Coordination, Review and Oversight (Therapies)

Each District will identify a Therapy Coordinator who will be responsible for coordination, review and oversight of therapy services.

The role of Health Care Services is to:

a. Consult with Division designee and/or District Therapy Coordinators on complex cases and offer a second opinion when requested.

b. Coordinate statewide meetings with District Therapy Coordinators to facilitate sharing of knowledge, resources and best practices.

c. Develop standard practices and policy.

d. Conduct random reviews of cases and monitor for trends identify issues and facilitate resolution.

602.13.8 Service Closure (Therapies)

Service closure shall occur in the following situations:

a. When services are no longer medically necessary as determined by the Planning Team.

b. The family /caregivers /program staff can meet the needs of the consumer.

c. When there is lack of progress towards the Individual Support Plan/Individualized Family Services

Plan/Person Centered Plan outcome and the service is not effective.

d. There is documentation of non-compliance with follow through on activities related to program by family/caregivers (may include attendance and lack of participation).

e. The consumer/family no longer wants the service.

A Notice of Intended Action must be sent in accordance with the processes defined in Chapter 2200 of this manual.

602.14 Respiratory Therapy

602.14.1 Service Description and Goals (Respiratory Therapy)

This service provides treatment to restore, maintain or improve respiration.

The goals of this service are to:

a. Provide treatment to restore, maintain or improve respiratory functions.

b. Improve the functional capabilities and physical well-being of the consumer.

602.14.2 Service Settings (Respiratory Therapy)

The Division does not authorize rates for respiratory therapy as a stand-alone service that is separate from other services provided in a particular setting. Although, respiratory therapy may be provided to the individual in any setting, it is part of the established rate for Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Nursing Facilities (NF).

602.14.3 Service Requirements (Respiratory Therapy)

Before Respiratory Therapy can be authorized, the following requirements must be met:

a. The service must be prescribed by a qualified, licensed physician as part of a written plan of care that must include the frequency, duration and scope of the therapy.

b. The provider must be licensed by the Arizona Board of Respiratory Care Examiners and be a graduate of an accredited respiratory care education program. This program must be accredited/approved by the American Medical Association's Committee on Allied Health Education and in collaboration with the Joint Review Committee for Respiratory Therapy Education.

c. The provider shall be designated for individuals who are eligible for Long Term Care services and registered with the Arizona Health Care Cost Containment System (AHCCCS).

d. Tasks may include:

    1. Conducting an assessment and/or review previous assessments, including the need for special equipment.

    2. Developing treatment plans after discussing assessments with the Primary Care Provider, the District Nurse and the Planning Team.

    3. Implementing respiratory therapy treatment as indicated by the assessment(s) and the consumer's treatment plan.

    4. Monitoring and reassessing the consumer's needs on a regular basis.

    5. Providing written reports to the Division staff, as requested.

    6. Attending Planning Meetings (Individual Support Plan/Individualized Family Services

Plan/Person Centered Plan meetings) if requested by the consumer and Division staff.

7. Developing and teaching therapy objectives and/or techniques to be implemented by the consumer, caregivers and/or other appropriate individuals.

8. Consulting with consumers, families, Support Coordinators, medical supply representatives and other professional and paraprofessional staff on the features and design of special equipment.

9. Giving instruction on the use and care of special equipment to the consumer and care providers.

602.14.4 Target Population (Respiratory Therapy)

This service is indicated for consumers who have a health condition that require respiratory therapy, as ordered by a physician, which is documented in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents).

602.14.5 Exclusions (Respiratory Therapy)

Respiratory Therapy is prohibited without Physicians orders and prescriptions for certain medical procedures. This requirement does not apply to private or state operated Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

602.14.6 Service Provision Guidelines (Respiratory Therapy)

Respiratory Therapy shall not exceed eight (8) fifteen (15) minute sessions per day.

602.14.7 Provider Types and Requirements (Respiratory Therapy)

Designated District staff will ensure all contractual requirements related to Respiratory Therapy providers are met before the service is approved. Additionally, all providers of Long Term Care

Services must be registered with the Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.14.8 Service Evaluation (Respiratory Therapy)

a. The Primary Care Provider (PCP) will review the plan of care at least every 60 days and prescribe continuation of service.

b. If provided through a Medicare certified home health agency, the supervisor will review the plan of care at least every 60 days.

c. The provider will submit progress notes on the plan of care on a monthly basis to the Division Support Coordinator.

602.14.9 Service Closure (Respiratory Therapy)

Service closure should occur in the following situations:

a. The physician determines that the service is no longer needed as documented on the “Plan of Care.

b. The consumer/responsible person declines the service.

c. The consumer moves out of State.

d. The consumer requires other services, such as home nursing.

e. The consumer/responsible person has adequate resources or other support to provide the service.

A Notice of Intended Action must be sent in accordance with the processes defined in Chapter 2200 of this manual.

The Division supports and encourages continuity of care among all therapy resources such as hospitals, outpatient rehabilitation clinics and schools. The Division contracted therapists shall collaborate with other service providers and agencies involved with the consumer.

602.14.10 Habilitative Therapy

Habilitative therapy directs the consumer's participation in selected activities to facilitate and/or improve functional skills. Additionally, habilitative therapy is described in terms of everyday routines and activities related to achieving the goals/outcomes described in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) and is based on needs identified in the these respective documents. Habilitative therapy is available through the Division and some Health Plans through Early and Periodic Screening, Diagnosis and Treatment Medicaid program. Habilitative therapy also provides for direct treatment by a licensed therapist.

Habilitative therapy may utilize direct treatment by a licensed therapist and is time limited and outcome driven. All therapy is consultative in nature.

602.15 Transportation (Non-Emergency)

602.15.1 Service Description and Goals (Transportation)

Non-emergency transportation shall be provided for consumers who are unable to provide their own transportation for medically necessary services. This service provides non-emergency ground transportation as prior approved by the Division if the consumer's natural supports cannot provide such transportation.

The goal of this service is to increase or maintain self-sufficiency, mobility and/or community access of eligible individuals.

602.15.2 Service Requirements (Transportation)

Transportation can be provided for individuals who are eligible for Long Term Care to and from other covered services.

602.15.3 Target Population (Transportation)

a. The need for transportation is assessed and documented by the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process.

b. Transportation is appropriate when consumer/family resources, supports or community resources are not adequate or available.

602.15.4 Exclusions (Transportation)

Exclusions for transportation services include:

a. Providers shall not transport more individuals than can travel safely.

b. Transportation for consumers who are eligible for Long Term Care Services to medical appointments should be coordinated through the health plan.

c. Consumers residing in Vendor Supported Child Developmental Homes and Vendor Supported Adult Developmental Foster Homes, Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Group Homes shall not receive additional transportation.

602.15.5 Service Provision Guidelines (Transportation)

a. Consumers who are eligible for Long Term Care services may use forty-six (46) trips per month to covered day programs.

b. Consumers who are eligible for Long Term Care services may use eight (8) trips per month to other covered services.

602.15.6 Provider Types and Requirements (Transportation)

Designated District staff will ensure all contractual requirements related to Transportation providers are met before services can be given. Additionally, all providers of Long Term Care services must be certified by the Division and registered with the Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

602.15.7 Service Evaluation (Transportation)

This service shall be reviewed at all Planning Team meetings.

602.15.8 Service Closure (Transportation)

a. This service shall be terminated when the consumer no longer requires transportation.

b. This service shall be terminated if other resources become available.

603 Acute Care Service Delivery

The Division, as a program contractor for Arizona Long Term Care System (ALTCS), is responsible to provide acute care services to individuals who are eligible for Long Term Care services. The Division provides these services through contracted health plans, a fee-for-service network in counties not served by a health plan, Indian Health Services (IHS) and the Comprehensive Medical and Dental Program (CMDP).

The Division's discretionary dollars may provide services or items when all other fund sources have been exhausted.

The Comprehensive Medical and Dental Program (CMDP) is the health plan for children in Foster Care who are also dependent wards of the court and ineligible for Arizona Long Term Care System (ALTCS). Service provision for these children has been transferred from Child Protective Services (CPS) to the Division.

603.1 Contracted Health Plans

Consumers who are eligible for Long Term Care services are required to join one of the Division's contracted health plans, where available. The exception is Native Americans who may choose to enroll in Indian Health Services (HIS).

The contracted health plan subcontracts with physicians, hospitals, therapists, dentists, laboratories, pharmacies, medical equipment suppliers and other providers to deliver acute care services to enrolled members.

All services must be delivered or ordered by the Primary Care Provider (PCP), determined to be medically necessary by the health plan and delivered by a contracted provider. The PCP is the consumer's designated physician who coordinates all aspects of the consumer's medical care. consumers who are eligible for Long Term Care services who fail to follow these procedures and receives services that are not approved/provided by a health plan provider are responsible to pay for these services.

The consumers who are eligible for Long Term Care services may choose to use their own doctor if the physician is an Arizona Health Care Cost Containment System (AHCCCS) registered provider and is contracted with the health plan. In these instances, the health plan's or the Division's approval is still needed for services covered by Arizona Long Term Care System.

If the consumer who is long term care eligible is enrolled in a health plan and has a Primary Care Provider (PCP), but also chooses to use another physician who may not be registered with AHCCCS, services provided or ordered by this physician are not covered by the AHCCCS. Services by a physician who is not registered with the AHCCCS can be covered by the health plan if approved by the PCP and the health plan. If approval is not received from the PCP and the health plan, the consumer will be required to pay for the services personally or through private insurance.

604 Acute Care Services

604.1 Inpatient Hospital

Inpatient hospital services are medically necessary services delivered or directed by a Primary Care Provider (PCP), a specialist physician, practitioner or dentist. These services are ordinarily furnished in an acute care hospital, except for services in public or correctional facilities, or Behavioral Health settings.

The following is a list of the minimum inpatient hospital services that are available to consumers who are eligible for Long Term Care services.

Routine services including:

a. Hospital room and board.

b. Medical supplies, appliances and equipment ordinarily furnished to hospital inpatients that are billed as part of routine services and are included in the daily room and board charge.

c. Intensive care and coronary care.

d. Nursing care.

e. Dietary management.

f. Up to seventy-two (72) hours of acute behavioral health services. The health plans will provide acute behavioral health services in accordance with Arizona Health Care Cost Containment System (AHCCCS) Rules for consumers not enrolled with a Regional Behavioral Health Authority (RBHA). The RBHA provides acute behavioral health services for their enrollees.

Supplementary services including:

a. Maternity services including labor, delivery, recovery rooms, and birthing centers.

b. Surgery, including operating and recovery rooms.

c. Clinical laboratory.

d. Radiological and medical imaging.

e. Anesthesiology.

f. Rehabilitation including speech, occupational and physical therapies.

g. Pharmaceutical services.

h. Respiratory therapy.

i. Receiving blood and blood products.

j. Receiving central supply items including appliances and equipment that are not ordinarily furnished to all patients and that are customarily reimbursed as additional services.

k. Nursery and related services.

l. Chemotherapy services.

m. Dialysis in accordance with Arizona Health Care Cost Containment System Rules (AHCCCS). azsos.gov/public_services/rules.htm

n. Total parenteral nutrition services.

o. Podiatry services, as covered in the Arizona Health Care Cost Containment System (AHCCCS) policy 2.14.0 9 (azahcccs.gov/Regulations/) performed by a podiatrist, licensed pursuant to A.R.S. Title 32, Chapter 7 (azleg.gov/ArizonaRevisedStatutes.asp), and ordered by a Primary Care Provider (PCP).

604.2 Outpatient Services

Outpatient health care services are those services provided outside of the acute care inpatient hospital setting. These include both palliative (designed to alleviate pain and discomfort) and therapeutic (designed to improved the condition) services directed or administered by a PCP. The services may be preventive, diagnostic or rehabilitative in nature. The following minimum outpatient health care services may be provided to individuals who are eligible for services through the Arizona Long Term Care System (ALTCS):

a. Ambulatory surgery and anesthesiology not specifically excluded by the AHCCCS Rules. azahcccs.gov/Regulations/

b. Physician services including patient education and routine physical examinations as designated by the

AHCCCS policy and procedures.
azahcccs.gov/Regulations/

c. Pharmaceutical services and prescribed drugs included in the Division's Formulary. Also including vaccines to prevent Hepatitis B, medically necessary psychotropics for the control of seizures and spasticity and non-prescription medication when cost-effective and prescribed by a physician.

d. Clinical laboratory services, including routine screening for Hepatitis B.

e. Radiological and medical imaging.

f. Services of nurse practitioners and physician assistants when referred by or under the supervision of a PCP.

g. Nursing services provided in an outpatient health care facility.

h. Covered medical supplies and equipment authorized by the member's PCP.

i. The use of twenty-four (24) hour emergency, examination or treatment rooms when required for the administration of physician services. Emergency room and medical emergency service will be provided 24 hours a day, 7 days a week.

j. Podiatry services, as covered in the Arizona Health Care Cost Containment System (AHCCCS) Policy and Procedure Manual 2.14.0 (azahcccs.gov/Regulations/), performed by a podiatrist, licensed pursuant to A.R.S. Title 32, Chapter 7 (azleg.gov/ArizonaRevisedStatutes.asp), and ordered by a Primary Care Provider (PCP).

k. Home physician visits as medically necessary.

l. Dialysis in accordance with the AHCCCS Rules.
azahcccs.gov/Regulations/

m. Specialty care physician services shall be considered covered services only when requested by a PCP.

n. Rehabilitation services including occupational, physical and speech therapies prescribed by a PCP and in accordance with the AHCCCS Rules. azahcccs.gov/Regulations/

o. Respiratory therapy.

p. Total parenteral nutrition services.

q. Enteral nutritional supplements when prescribed as medically necessary by a PCP.

r. Annual physical examinations for adults and children, periodic health examinations, health assessments, physical evaluations, diagnostic procedures or health protection packages, that include groups of tasks or procedures designed to:

1. Determine risk of disease.

2. Provide early detection of disease.

3. Detect the presence of injury or disease at any stage.

4. Establish a treatment plan for injury or disease.

5. Evaluate the results or progress of a treatment plan for the disease.

6. Establish the presence and characteristics of a physical disability that may be the result of disease or injury.

s. Outpatient behavioral health services, including psychotropic medications, in accordance with the AHCCCS Rules.

t. Medically necessary home nursing in lieu of hospitalization when ordered by the Primary Care Provider (PCP).

u. Hospice services.

604.3 Clinical Laboratory, Radiological and Medical Imaging Services

Clinical laboratory procedures (including routine screening for Hepatitis B), radiological and medical imaging services prescribed by a Primary Care Provider (PCP) or by another physician, practitioner or dentist upon referral by a PCP and which are ordinarily administered in hospitals, clinics, physicians' offices or other health care facilities by licensed health care providers shall qualify as covered services if medically necessary.

Clinical laboratory, radiological and medical imaging service providers shall satisfy all applicable State license and certification requirements, be registered with the Arizona Health Care Cost Containment System (AHCCCS), and shall perform only those services specific to their license and certification.

604.4 Pharmacy

Pharmaceutical services include medically necessary drugs prescribed by Primary Care Provider (PCP), other physicians, practitioners or dentists upon referral by a PCP Psychotropic drugs for the control of seizures and spasticity shall be covered, as well as vaccines used to prevent Hepatitis B. At a minimum, items listed in the Division's Formulary shall be included as covered benefits for individuals who are eligible for Long Term Care services.

Psychotropic drugs for behavioral health symptoms shall be covered according to the AHCCCS Rules.

Prescriptions shall be dispensed with a 30-day supply of medication, if authorized by the prescriber.

Pharmaceutical services shall be available to consumers during customary business hours and shall be located within reasonable travel distance.

604.5 Medical Supplies, Durable Medical Equipment, and Prosthetic Devices

Medical supplies, durable medical equipment orthotic and prosthetic devices provided to consumers who are eligible for Long Term Care services qualify as covered services if prescribed by a, specialist physician, practitioner or dentist upon referral by a PCP.

Documentation from therapists who have treated the consumer may be required. That documentation must establish the need for equipment and a comprehensive explanation of how the individual will benefit from the equipment.

Experience has demonstrated that the cost-effective provision of Durable Medical Equipment includes the involvement of a physical therapist in ordering and fitting customized equipment.

Medical supplies and Durable Medical Equipment include:

a. Surgical dressings, splints, casts and other disposable items covered by Medicare (Title XVIII).

b. Rental or purchase of Durable Medical Equipment, including, customized equipment.

c. Other items as determined medically necessary by joint consultation of the Medical Directors of the health plan and the Division.

604.6 Adaptive Aids

Certain medically necessary adaptive aids qualify as a covered service if prescribed by a specialist physician, practitioner or dentist upon referral by a Primary Care Provider (PCP).

Documentation from therapists who have treated the consumer may be required. That documentation must establish the need for equipment and a comprehensive explanation of how the individual will benefit from the equipment. It is important to remember that this service is based on “assessed need” and not a person’s or the family’s stated desires regarding specific services.

Covered adaptive aids are limited to:

a. Traction equipment.

b. Feeding aids (including trays for wheelchairs).

c. Helmets.

d. Standers, prone and upright.

e. Toileting aids.

f. Wedges (positioning).

g. Transfer aids.

h. Augmentative communication devices.

i. Medically necessary car seats.

j. Other items as determined medically necessary by joint consultation of the Medical Directors of the health plan and the Division.

604.7 Augmentative Communication Devices

604.7.1 Service Description and Goals (Augmentative Communication Devices)

Augmentative communication devices are those devices that enhance a consumer's ability to communicate with others at his/her highest level of independence.

604.7.2 Service Settings (Augmentative Communication Devices)

Augmentative communication devices are appropriate for use in all settings.

604.7.3 Service Requirements (Augmentative Communication Devices)

The consumer and their Individual Support Plan/Individualized Family Services Plan/Person Centered (Planning Team) team must identify the need for an augmentative/alternative

communication evaluation. This determination shall be made by using the Pre-Admission Screening (PAS) tool, the Inventory for Client and Agency Planning (ICAP) tool and any other available information to assess whether there may be a functional gap between the consumer's receptive and expressive language skills, and/or the consumer demonstrates communicative intent as determined by the Communicative Intent Checklist (Appendix 600.L). The Support Coordinator must prepare a packet of information and forward it to Health Care Services in Central Office within 15 working days of the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan meeting (Planning Meeting). The packet must include all of the following:

a. The completed Augmentative Communication Referral Checklist (Appendix 600.M).

b. The current Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) that includes long-term communication goals.

c. A prescription for the augmentative/alternative communication evaluation and equipment as needed, dated within the past 12 months.

d. A speech and language evaluation dated within the past 12 months.

e. The current Individual Education Plan (IEP) if school age.

f. Documentation of previous use of low technology devices such as picture boards or dial scanners.

g. Occupational therapy evaluation dated within the past 12 months if the consumer has fine/sensory motor problems that may impact the ability to touch a small target square, to push hard enough to operate a switch or if there are limitations in the consumer range of motion or head control.

h. Physical therapy evaluation dated within the past 12 months if the individual has seating, positioning, and/or mobility needs related to augmentative/alternative communication device use.

i. Formal or functional hearing test within the past 12 months.

j. Formal or functional vision test within the past 12 months.

k. Therapy progress reports, if therapy has been provided during the past 12 months.

l. Third-party liability (TPL) insurance information.

m. Any previous or current augmentative communication evaluation reports, if available.

n. Any other reports relating to the acquisition of the skills and/or abilities necessary to operate an augmentative/alternative communication device, if available, i.e., a current psychological/psycho-educational evaluation, wheelchair/seating clinic evaluations, etc.

An evaluation conducted by the school system is acceptable for school age individuals.

Health Care Services will either refer for further evaluation or order the device, as appropriate within 15 working days of receipt of the complete packet. Further evaluations may include referral to the contracted Augmentative/Alternative Communication Evaluation Team, Rehabilitation Engineering for access assessment or medical review.

Once the device is obtained, it will be sent to the Support Coordinator. The Support Coordinator delivers the device and obtains the responsible person's signature on the Acknowledgment of Receipt of Durable Medical Equipment form (Appendix 600.N). This form is to be retained in the consumer's

case record, with a copy sent to Health Care Services. Training on the use of the device will be arranged per case.

604.7.4 Target Population (Augmentative Communication Devices)

Consumers who are potentially eligible for communication systems are those who show communicative intent but whose expressive skills are currently below their receptive language skills and are not adequately meeting their day to day functional communication needs. For example**,** consumers may attempt to communicate through non-verbal approaches such as pointing, gesturing, signing, vocalizing sounds or eye gazing. Receptive language refers to understanding of spoken language, while expressive language refers to language output (traditionally speech). Such individuals may be candidates for an intervention strategy that includes the use of alternative forms of expressive communication. For such a strategy to be effective, other factors must be considered to ultimately guarantee benefit to the consumer, e.g., the long term goal, appropriate outcomes, evaluation methods, mode of learning, follow up training and overall quality of life.

604.7.5 Exclusions (Augmentative Communication Devices)

Augmentative communication devices will not be provided under the following circumstances:

a. The consumer has received appropriate teaching and therapeutic strategies and the prognosis for developing effective oral communication is poor.

b. The consumer does not demonstrate the ability to make choices independently.

c. The consumer will use the device solely in an educational setting.

d. The consumer has used light/high technology communication systems and has not demonstrated the intent to communicate.

e. The consumer has a history of destructive behavior and a plan of intervention has not been identified.

f. The Planning Team outcomes and goals do not indicate a commitment to use the device in all settings.

604.7.6 Service Provision Guidelines (Augmentative Communication Devices)

The following service provision guidelines apply to augmentative/alternative communication devices:

a. Devices will not be provided if not medically necessary and prescribed by the Primary Care Provider (PCP).

b. One (1) device and the medically necessary accessories for operation will be provided.

c. Only one (1) option will be provided (other options must be furnished by an alternative resource) if a device can be equipped with both voice and print capabilities.

d. One (1) mount will be provided unless a second is medically necessary.

e. Children under the age of 3 (who are referred as possible candidates for a device) will have their needs reviewed on an individual basis. Toys are not a covered item.

f. Replacement of equipment is covered in the following situations:

1. Loss or irreparable damage or wear not caused by carelessness or abuse.

2. Equipment replacement is recommended by an authorized re-evaluation. Re-evaluations for the purpose of upgrading the device will not be

authorized for 6 months after the receipt of the current device.

Re-evaluations may be obtained if the current device is not meeting the consumer's needs despite adequate training of at least 3 months, there is a change in the consumer's medical condition, or communication goals were met or exceeded with the current system. Re-evaluations must include the same requirements as noted in Section 604.7.3 of this Chapter.

604.7.7 Evaluation (Augmentative Communication Devices)

The Support Coordinator must perform a review of the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) as noted in Chapter 1000 of this Manual.

604.7.8 Service Closure (Augmentative Communication Devices)

All devices and accessories will be returned to the Division when no longer medically necessary as determined by the Individual Support Plan, Individualized Family Services Plan or Person Centered Plan (Planning Documents). The device and accessories must be returned to the Division if the consumer is moving out of state. The Support Coordinator is responsible for picking up the device and accessories and returning them to Health Care Services. Health Care Services will then arrange for the device to be refurbished and reused.

604.8 Dental Services

a. Dental services for consumers who are Long Term Care eligible aged 0 to 21 years are covered when provided by a licensed dentist per A.R.S. §32-1207 and A.R.S. §32-1231 (azleg.gov/ArizonaRevisedStatutes.asp) for maintenance of dental health, prevention and treatment of disease and injury, in an appropriate dental facility.

Informed consent must be obtained from the consumer or responsible person(s) prior to any treatment including those noted in #1 below. Written

consent must be obtained prior to major outpatient treatments. The dentist must obtain the consent.

The following services are covered:

1. Preventive dental services - performed annually unless otherwise requested by Primary Care Provider (PCP) include:
    a. Oral examinations.
    b. Radiological and medical imaging services.
    c. Oral prophylaxis - includes scaling and polishing and application of topical fluoride and sealants, if appropriate.
    d. Dental treatment plan.
    e. Dental education.
2. Restorative treatment, including:
    a. Restorative and primary amalgams.
    b. Composite restoration (anterior teeth).
    c. Sedative base.
    d. Permanent teeth.
3. Orthodontia when medically necessary and prior authorized by the health plan or the Division's Medical Director.
4. Endodontics services (pulp capping, pulpotomy and recalcification).
5. Crown and bridge services.
6. Prosthetics.

7. Oral surgery includes extraction of symptomatic teeth and post-operative visits.

8. Orthognathic surgery.

9. Medically necessary dentures.

b. Emergency dental care and extractions are covered for all consumers who are eligible for Long Term Services, regardless of age.

604.9 Rehabilitative Therapy

Rehabilitation is the process of re-establishing former functions or skills. This includes physical, occupational and speech therapies. This service may occur after a trauma has decreased the functioning of a consumer. Rehabilitative therapies are not designed to build a skill or functioning level that had not been previously present in the individual. Refer to Chapter 1400 of this Manual for Behavioral Health Rehabilitative Therapy.

604.10 Maternal and Child Health

There are several programs that support maternal and child health. These include Early and Periodic Screening, Diagnosis and Treatment (EPSDT), family planning, pregnant women's program and mental health. These programs are described below:

a. EPSDT is the component of the Medicaid Program established in 1969 as the federally mandated screening and treatment program for children birth to age 21.

The goal of EPSDT is to provide health care through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems identified by well child checks and screens.

An EPSDT must include:

- A comprehensive health and developmental history (including both physical and behavioral health assessment).
- As of january 1, 2006, the Prenatal Evaluation of Development Status (PEDS) developmental screening tool should be utilized for developmental screening by the primary care provider for EPSDT-age consumers who were admitted to the neonatal intensive care unit. The PEDS screening should also be conducted at each EPSDT well child visit.
- A comprehensive unclothed physical examination.
- Appropriate immunizations according to age and health history.
- Laboratory tests (including blood lead levels).
- Health education.
- Appropriate dental screening.
- Appropriate vision screening and hearing testing.
- Diagnostic services whenever a screening examination indicates the need to conduct a more in depth evaluation of the child's health status and to provide diagnostic studies.

As the Medicaid authority in Arizona, AHCCCS administers the Early and Periodic Screening Diagnosis and Treatment program. Children who are eligible for Medicaid are eligible for EPSDT services. Children who are eligible for Long Term Care services are also Medicaid eligible. Additionally, these children are eligible for EPSDT services.

Arizona Health Care Cost Containment System (AHCCCS), contracts with health plans to provide all

EPSDT services to all AHCCCS eligible children in Arizona.

The Division also contracts with the health plans to provide EPSDT services to children who are Long Term Care eligible. The Division provides those services identified as habilitative to children who are Long Term Care eligible. The health plans are under contract to provide rehabilitative services to children who are Long Term Care eligible.

Medicaid funds are available to pay for medically necessary services identified for a child with a disability in his/her Individual Educational Plan, Individual Family Service Plan, Individual Support Plan or Person Centered Plan.

All services authorized in the federal Medicaid law must be provided to children who are eligible for EPSDT. These services include:

– Screening.

– Evaluation.

– Clinic services.

– Rehabilitative services.

– Physical therapist services.

– Occupational therapist services.

– Speech pathology and audiology services.

– Psychological Treatment.

– Social services.

– Inpatient psychiatric facility services.

– Outpatient behavioral health services.

An authorization for services can only be denied for lack of a finding of medical necessity. It cannot be denied for any other reason for children who are eligible for the AHCCCS program and Division services.

EPSDT means those procedures or professional services which are required to maintain, correct or ameliorate a physical, emotional or developmental problem which is discovered through screening, examination or evaluation or which is found to have worsened since a previous screening.

For more detailed information on EPSDT, refer to the AHCCCS Medical Policy Manual at Section 430. azahcccs.gov/Regulations/

b. Family Planning - Medicaid allows for the provision of Family Planning Services. The goal of Family Planning Services is to enable a consumer to make choices in both the timing and occurrence of pregnancies. This service is available through the consumer's Primary Care Provider (PCP) and is part of the services offered by the health plans. Division health plans are required to educate their Providers on the full scope of available family planning services and how members may obtain them.

c. Pregnant Women's Program - One step toward accomplishing this goal is to ensure that pregnant women receive early and continuous prenatal care from a qualified obstetrical provider. Prenatal care is arranged through the consumer's PCP.

d. Behavioral Health Programs – consumers who are eligible for Long Term Care services needing behavioral health services may be referred by their Division Support Coordinator, the Division Behavioral Health Coordinator, the physician or by themselves to a Regional Behavioral Health Authority (RBHA) for evaluation and service planning. Covered services must comply with the Arizona Health Care Cost

Containment System's (AHCCCS) behavioral health policies and procedures. Inpatient and outpatient services are covered as well as appropriate prescription drugs.

604.11 Podiatry

Routine foot care can be covered when the performance of such services by other than professional individuals would be hazardous to consumers who have concurrent diseases such as diabetes mellitus or thrombophlebitis.

604.12 Organ Transplant

Organ transplant services and procurement shall be in accordance with AHCCCS Rules (azahcccs.gov/Regulations/).Organ transplant services also require written prior authorization from the Division and AHCCCS.

604.13 Extended Care Coverage

Health plans for consumers who are eligible for Long Term Care are financially responsible for a maximum of 90 days. This financial responsibility includes nursing facility care, and room and board, after -hospital discharge. Nursing Facility (NF) care must be in lieu of hospitalization. If the consumer's place of residence prior to hospitalization was a NF the health plan is not financially responsible for placement. Consumers requiring nursing facility placement beyond 90 days are the financial responsibility of the Division. Preadmission Screening/Annual Resident Review (PASRR) Level II reviews must occur for each consumer whose expected stay in the NF will exceed 90 days (see Chapter 800).

Division staff will work expeditiously with the health plan's discharge planners to place the consumer in the least restrictive environment as required by state law.

604.14 Home Health Services

Home health services through the health plan are those services provided by a Home Health Agency that coordinate in-home intermittent services. These services include, home health aide

services, medical supplies, equipment and appliances. The service must be ordered by the Primary Care Provider (PCP) in lieu of hospitalization and referred by the health plan to a Medicare Certified Home Health Agency.

604.15 Emergency Ambulance and Medically Necessary Transportation

Emergency transportation via ground or air ambulance and transportation to access acute care services is a covered benefit. Transportation services are limited to occasions when no other means of travel is appropriate or available or in emergency situations. The nearest provider or medical facility capable of meeting the consumers medical needs shall be utilized.

604.16 Travel Expenses (Meals, Lodging, Transportation and Attendant Services)

Expenses incurred for meals, lodging and transportation for a member while en route to or from a health care service site out of the consumer's service area or county of residence are covered services.

The Primary Care Provider (PCP) must write an order for attendant care services. The Attendant Care Provider's meals, lodging and transportation expenses are covered. On occasion the Attendant Care Provider may accompany a member out of the service area or county of residence. These Attendant Care Providers may also be a family member who lives in the same household as the individual. Under these circumstances services are covered if a written order from the PCP is issued. The Attendant Care Provider's salary is covered only if the attendant does not live in the same household as the consumer. Expense receipts must be sent to the health plan or Health Care Services for fee-for-service counties. Receipts for meals and lodging must not exceed the State per diem. Transportation will be reimbursed at 9 cents per mile.

The following exclusions and limitations apply:

a. Family household members, friends and neighbors may be reimbursed for providing transportation services only if the services are ordered in writing by

the PCP and free transportation or public transportation is not available.

b. A charitable organization providing transportation services at no cost. A charitable organization may not charge or seek reimbursement for the provision of such services to Long Term Care.

c. Payment for meals, lodging and transportation of an individual and an Attendant Care Provider are funded when a consumer requires covered service that are not available in the health plan's service area. This criterion also applies to the salary for an attendant.

604.17 Out-Of-Area Coverage

Covered services are required to be provided within the service area of the health plan except as follows:

a. Referral of a consumer by a Primary Care Provider (PCP), out of the health plan's service area for medical specialty-care (including Children's Rehabilitative Services).

b. Services for consumers traveling or temporarily residing out of their health plan's service area are restricted to emergency care services, unless otherwise authorized by the health plan.

c. A covered service is not available within the health plan's service area.

d. A net savings results from transportation to another area for services.

e. The health plan provides written authorization for services based on cost or scope of service considerations.

604.18 Diapers

Diapers are coverings for the purpose of containment of either urine or feces for individuals who rare at risk for incontinence of

either urine or feces. Diapers may be cloth or a paper product treated for enhanced absorbency.

Diapers are considered "incontinent supplies." Arizona Health Care Cost Containment System (AHCCCS) Policy 310 (Covered Services, azahcccs.gov/Regulations/) does not cover incontinent supplies unless determined medically necessary.

Diapers are medically necessary only in the following situations:

a. Regulation and calculation of input and output for such conditions as diabetes insipidus, colitis, sprue or other gastrointestinal or metabolic disturbances requiring repeated fluid management. Such conditions shall be documented and monitored by a licensed physician.

b. A licensed physician has documented that an identified infection that is also contagious needs to be controlled for a specified period of time.

c. A dressing for an identified dermatological condition is needed as documented by a licensed physician.

d. The Division Medical Director reviews and approves the need for diapers for other medical conditions.

The most medically appropriate, cost effective diapers will be provided if diapers are found to be medically necessary.

604.19 Supplemental Nutritional Feeding

This policy provides criteria for the evaluation and authorization of supplemental nutritional feedings (oral-enteral formula) for consumers eligible for Long Term Care covered services through the Division. It also addresses the issue of medical necessity, assessment and authorization of non-specialty formula.

604.19.1 Criteria for Medical Review and Prior Authorization for Supplemental Nutritional Feeding

a. The Primary Care Provider (PCP) or physician specialist must make the request. A Physician has

requested nutritional feeding by a physician assistant or nurse practitioner. In order to make this request, the physician assistant or nurse practitioner must be under the medical management of the PCP. A request made by a physician specialist must be routed through the PCP for continuity of care. Requests shall be routed through appropriate channels of the health plan or to the Prior Authorization Nurse in Health Care Services for fee-for-service. Items to be submitted for medical review include:

1. All current diagnoses.

2. Current or recent (within 6 months) laboratory data such as chemistry panel, iron binding studies, etc.

3. Growth chart with current height and weight history. A family history of unusual growth patterns, i.e., emaciated, short stature, etc. should be included, as appropriate.

4. The history of ambulation or physical activities.

5. The history of gastrointestinal health.

6. A current nutritional assessment and a summary of client/caregiver education done by a registered dietitian (see Appendix 600.O for a sample assessment).

7. A three (3), five (5) or seven (7) day diary of dietary intake, as appropriate.

8. The speech or occupational therapy evaluation related to any oral-motor, dentition, chewing or swallowing problems, as applicable.

9. Current medications including an analysis of possible medication/nutrient interaction affecting absorption.

10. All alternative approaches to the use of oral-enteral formulas attempted and the outcomes.

11. The specific goals of oral-enteral formulas with a follow-up and weaning plan over a specific time frame.

b. Monitoring of the client's progress on the oral-enteral formula is the responsibility of the Primary Care Provider (PCP) or designee and shall include:

1. Nutritional assessment follow-up at the following intervals:

a. Consumers on oral-enteral formulas less than five (5) years shall receive an assessment every three (3) months.

b. Consumers on oral-enteral formulas five (5) to fourteen (14) years shall receive an assessment every six (6) months.

c. Consumers on oral-enteral formulas over fourteen (14) years shall receive an assessment annually.

2. Alternatives to commercially prepared formulas should be considered whenever possible including blenderized foods for individuals beyond the normal formula age (3 years) if possible.

c. Consumers who are eligible for the Women, Infant and Children (WIC) program should be encouraged to use that program first. The Division's fee-for-service or the subcontracted health plan will make up the difference between the WIC Program, the authorized amount and the PCP requested amount.

604.19.2 Client Management for Supplemental Nutritional Feeding

a. Consumers should be followed by:

1. The health plan.

2. The agency providing the formula.

3. The Division's Health Care Services for fee-for service.

604.19.3 Authorization Process for Supplemental Nutritional Feeding

a. Definitions

1. Enteral - "within or by way of the intestine." For the purposes of this policy, enteral will mean the delivery of nutritional feedings to the intestinal tract by way of a feeding tube such as naso-gastric, oral-gastric, gastrostomy, jejunostomy or a gastrostomy button.

2. Oral - any nutritional formula or food that is ingested by mouth.

b. Authorization guidelines

1. Authorization for oral-enteral formula or supplemental nutritional feedings will be granted if the following criteria are met. The health plan Medical Director or the Division Medical Director must also deem oral-enteral formula or supplemental feedings as medically necessary for Fee for Service. The criteria for authorization are as follows:

a. The consumer is at or below the 10th percentile on the appropriate growth chart for their age, gender or disability, e.g., Down syndrome, for greater than three (3) months.

b. The consumer has reached a plateau in growth and/or nutritional status for greater than six (6) months (pre-pubescent).

c. The consumer has demonstrated a decline in growth status within the last three (3) months.

d. The consumer is able to obtain/eat no more than 50% of his/her nutritional requirement from normal food sources.

e. Absorption problems as evidenced by emesis, diarrhea, dehydration, weight loss and intolerance to milk or formula products have been ruled out.

f. Unsuccessful trials of alternatives such as blenderized foods have been documented over a reasonable period of time with the involvement of a nutritionist.

2. The Prior Authorization Nurse will submit all documentation for evaluation by the health plan Medical Director or the Division Medical Director regarding fee-for-service.

3. Re-authorization for supplemental nutritional feeding formula will be determined by the age of the consumer (based on the nutritional evaluation for age set forth in Section 604.19.1.b).

604.20 Service Provision Guidelines

Covered services may be limited in amount, duration and scope. Certain services are specifically excluded from coverage. These limitations and exclusions are documented in AHCCCS Rules and apply to all covered acute care services. Exclusions include:

a. Services rendered by non-registered providers.

b. Services or items furnished solely for cosmetic purposes.

c. Services for which required prior authorization was not obtained from the health plan.

d. Services or items furnished gratuitously or for which charges are usually not made.

e. Services rendered in a public institution for treatment of tuberculosis or for the treatment of mental disorders for individuals between ages 21 and 65.

f. Hearing aids for members age 21 and older.

g. Treatment and services determined to be experimental or provided primarily for the purpose of research.

h. Services of a private or special duty nurse except when medically necessary and with prior authorization by the health plan.

i. Sex change operations.

j. Reversal of voluntarily induced infertility;

k. Care not deemed medically necessary by Health Care Services, the Primary Care Provider (PCP) or not included in the Arizona Health Care Cost Containment System AHCCCS) Rules. azahcccs.gov/Regulations/

l. Medical services provided to a member who is an inmate of a public institution as defined in Chapter 42 Code of Federal Regulations 435.1009 (www.gpoaccess.gov/cfr/) or who is in the custody of a State mental health facility.

m. Artificial, mechanical, or xenograft heart transplant.

n. Organ transplants except those specifically covered by A.R.S. §36-2907(A)(E)(F) azleg.gov/ArizonaRevisedStatutes.asp as authorized by the health plan.

o. Abortions not medically necessary.

p. Hysterectomies which are not medically necessary.

q. Abortion counseling.

r. Optional family planning clinic services as defined by federal law.

Services cannot be denied based on moral or religious grounds.

605 Individual and Family Assistance

Individual and Family Assistance is flexible support funding intended to enable families to care for children at home and for adult consumers to live independently in their communities. Individual and Family Assistance is based on available funding and is not intended to replace natural or other means of support and assistance. They may be Emergency Support or Ongoing Support as described below.

General Guidelines

All payments from these funds must be made to a vendor, not the family or individual consumer unless extenuating circumstances prevent it. For instance, in the case of rent subsidy payable to a family member who is renting to a consumer All exceptions must be prior approved in writing by the District Program Administrator) Services that may be purchased with Individual and Family Assistance funds include those listed in the Arizona Taxonomy of Services, as well as financial assistance for specific purposes. these services may include:

- Automotive repairs (if the vehicle is unable to be driven and would put the individual at risk if not repaired)
- Clothing
- Corrective lenses
- Dental needs
- Diapers
- Equipment repairs
- Medication

- Moving expenses
- Rent and/or living subsidy
- Transportation
- Utilities

Payments may produce a Federal Income Tax form 1099 that is sent to the recipient of these funds.

605.1 Receipts

Receipts must be obtained for all purchases/payments with few exceptions. Exceptions may include ongoing rent so long as an annual rental agreement is on file, showing monthly rent with beginning and end dates. Receipts may also be submitted in the form of a bill or invoice in the case of utility bills or monthly service fees. Receipts are to include the following information:

- Vendor name/place of business
- Date of purchase
- Description of item(s) purchased
- Name of Individual
- Name of Support Coordinator

All disbursements from Individual and Family Assistance funds shall be documented as expended by submission of the original itemized receipt(s) within thirty days. No further funds shall be granted to the vendor until the receipts are submitted, unless approved by the District Program Administrator/Manager or in case of health and safety concerns.

The funds may only be spent for the approved purchase and not for any other items. If there are any excess funds, they are to be returned to the Division.

605.2 Emergency Support

Emergency Support provides a one-time payment in emergent or extraordinary circumstances to eligible families on behalf of a consumer with a developmental disability living in the family home, or (for an adult) in either the family or her/his own home or in rare cases for an consumer living in a vendor operated setting

with prior written approval by the District Program Administrator/Manager for health and safety purposes.

One-time payment amounts typically should not exceed $500 per individual consumer or family. Any amounts over $300 require District Program Manager/Administrator approval.

605.2.1 Eligible Services – Emergency Support

Only authorized services may be purchased with Individual and Family Assistance funds. Authorized services are those recommended by the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Team) and approved by the District Program Administrator/District Program Manager or designee. The Division will only approve services that can be purchased at a reasonable cost.

Emergency Support cannot be used to supplement the level of services already furnished to the family or consumer under Division contracts with service providers.

Emergency Support cannot be used to purchase services otherwise readily available to the family or consumers who are eligible for Long Term Care Services. Emergency Support is not available for Licensed Child Developmental or Adult Developmental Homes unless for health or safety matters not funded elsewhere Individuals who have failed to take all reasonable steps to enroll in the Arizona Long Term Services program are not eligible for Emergency Support.

Other service options must be explored in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and, if appropriate, applications for alternative services or benefits may be made a condition of eligibility to receive Individual and Family Assistance. These alternatives might include:

a. Arizona Long Term Care Services;

b. Income supplements such as Supplemental Security Income, Social Security Survivors Benefits, Social Security Disability Income, Railroad Retirement, Veterans Administration, Temporary Assistance to

Needy Families, General Assistance and Emergency Assistance;

c. Food stamps, Women, Infant and Children Program and food banks;

d. Housing benefits available through Housing and Urban Development;

e. Vocational Rehabilitation and the Job Training Partnership Act Program;

f. Benefits rendered because of injury to persons or property;

g. Education programs;

h. Child support and adoption subsidies;

i. Arizona Health Care Cost Containment System, Medicare, Indian Health Services and private health insurance;

j. Supplemental Payments Program and benefits furnished under the Older Americans Act.

605.2.2 Eligibility-Emergency Support

All consumers/families must meet the following criteria to receive Emergency Support:

a. Enrolled in the Division service system.

b. Participation in the program by parent, other close relative, legal guardian or by the consumer. This participation usually takes the form of a co-payment for services.

c. Require funds for health or safety concerns for which no other funding is available.

605.2.3 Determination of Participation by Responsible Person

The Individual and Family Assistance/Emergency Support funds are intended to form a partnership between families and the Division in meeting the needs of children or adults who live at home, or in independent or supported living arrangements not contracted as residential programs by the Division.

Emergency Support is “needs-based” and is not tied to a specific income eligibility level unlike the Arizona Long Term Care System. Families must demonstrate their co-pay participation related to cost for the service, item or other purchase to be eligible for Emergency Support.

In the case of an adult with a developmental disability living in her/his own home, the consumer must be able to demonstrate how much income is devoted to shelter and food before Individual and Family Assistance/Emergency support payment can be approved. The consumer must also demonstrate how much income is devoted to an Individual Support Plan Team-approved program before an Emergency Support payment can be provided. The consumer’s remaining resources are available for personal and incidental expenses. Consumer’s with more than $3,000 in liquid assets (cash) are ineligible for Assistance to Families funds.

The Support Coordinator and consumer/individual shall complete the Individual and Family Assistance Request Worksheet and Agreement (Appendix 600.G) when requesting participation in this program. The Planning Team shall review these documents and forward them, with a recommendation, to the District Program Manager/District Program Administrator or designee. The packet must reflect the items or services funded by Emergency Support dollars, the type and amount of support, and the level of participation by the consumer or family.

605.2.4 Guidelines for Approving Emergency Support

The District Program Manager/District Program Administrator (or designee) shall consider the following factors in evaluating requests for Emergency Support:

a. Age and/or health status of the parents/family members.

b. Complexity of the consumer's needs the stress that these place on the family, and the family's ability to respond to that stress.

c. Degree of consumer or family participation in the cost of services relative to their means.

d. Degree to which the consumer/individual is already receiving other Division funded services.

e. Availability of funding from all sources.

f. Reason for the emergent or extraordinary request.

The District Program Manager/District Program Administrator should respond to a request for Emergency Support within five (5) working days of the recommendation by the Planning Team.

605.2.5 Payments

Services are authorized and participation/co-payments identified on the Individual and Family Assistance Worksheet and Agreement (Appendix 600.G). If approved, the payment will go directly to the vendor identified by the consumer or family.

605.2.6 Waivers

The District Program Administrator/District Program Manager must approve any waivers for procedures or family participation. The waiver is only allowed if the goals and intent of the program are otherwise met.

The consumer, family or Support Coordinator is permitted to initiate a written request for a waiver. The Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team may also initiate a written waiver request. The request must identify the specific requirements to be waived. The District Program Administrator/District Program Manager will determine whether approval of the requested waiver will enable the goals and intent of the program to be met. The District Program

Administrator/District Program Manager will respond to the initiator of the request, in writing, within 10 working days. Payments to other than a vendor must also be approved by the Division's Business Operations Administrator.

605.3 Ongoing Support

Ongoing Support is an on-going payment to a vendor intended to support the family's effort to maintain its family member with a disability in the family home, thereby preventing out-of-home placement; or to support an adult to live in their own home, thereby preventing placement in more restrictive settings. Payments are made directly to the vendor identified by the individual consumer or family or in the case of consumers living in Individually Designed Living Arrangements (IDLA), payments may be made to the provider who will make payments to landlords, utilities and other living cost on behalf of a consumer.

When Ongoing Support payments are made to a provider for consumers living in an IDLA, the provider is required to maintain a detailed expenditures log for each consumer identifying all expenditures on behalf of the consumer, including:

- Date
- Vendor
- Purchase/payment detail
- Amount
- Declining balance with all supporting documentation and receipts attached.

This expenditure log must be made available to the Division and/or the guardian upon request at any time.

605.3.1 Eligible Services – Ongoing Support

The Division will only approve services that can be purchased at a reasonable cost and that advance/meet the goals of the Individual and Family Assistance program and the Division.

605.3.2 Ineligible Services

Ongoing Support cannot be used for the following:

a. Services available under Arizona Long Term Care System

b. Consumers who live in developmental homes, group homes, Intermediate Care Facilities for the Mentally Retarded, Nursing Facilities or Assisted Living Centers

c. Consumers who have failed to take all reasonable steps to enroll in the Arizona Long Term Care System

d. Families with income that exceeds 300% of the federal poverty level. Currently the federal poverty level is $20,000 for a family of four: 300% = $60,000 and 29,400 for an individual per the Federal Register which is updated annually.

605.3.3 Alternative Options

The Individual Support Plan/Individual Family Services Plan/Person Centered Plan team members must explore other service options and, if appropriate, applications for alternative services or benefits may be made as a condition of eligibility to receive Ongoing Support. These alternatives include:

a. Arizona Long Term Care System

b. Income supplements such as Supplemental Security Income, Social Security, Social Security Disability Income, Railroad Retirement, Veterans Administration, Temporary Aid to Needy Families, General Assistance and Emergency Assistance

c. Food stamps, Women Infants and Children Program and food banks

d. Housing benefits available through Housing and Urban Development and other housing assistance

e. Vocational Rehabilitation and assistance through the Job Training Partnership Act

f. Education programs

g. Child support and adoption subsidy

h. Arizona Health Care Cost Containment System, Medicare, Indian Health Services and private health insurance

i. Supplemental Payment Program and benefits furnished under the Older Americans Act

j. Other community and religious based services and programs

605.3.4 Eligibility

All consumers/families must meet the following criteria during any month wherein Ongoing Support is received:

a. Enrolled in the Division service system

b. Participation in the program by parent, other close relative, legal guardian or by the consumer. This participation usually takes the form of a co-payment for goods or services although it may involve participation in the form of a contribution of labor. Consumers in an Individually Designed Living Arrangement with no familial supports or source of other income or require extensive supports and medically or behaviorally unable to participate in their own service delivery may be exempt from this requirement.

605.3.5 Determination of Participation by Responsible Person

Whenever possible, families or consumers must demonstrate their participation in the cost of service, item or other purchase to be eligible for Community Living Support.

The consumer must be able to demonstrate how much income is devoted to shelter, food and program cost. The Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team must approve the programs referenced. The consumer's remaining resources are available for personal and incidental expenses. consumers with more than $1,500 cash or $2,000 in

liquid assets are ineligible for Ongoing Support. The consumer's Ongoing Support payment will be interrupted or terminated until they can demonstrate the need for continued or renewed support.

The Support Coordinator and the Planning Team shall review these documents, the family's resources and any funds the individual may have:

- Savings and checking accounts
- Bonds
- Trust funds
- Tort-feasor (civil judgments) funds
- Annuities
- Estates
- Wages
- Benefits
- Child support payments
- Other financial resources and income

They shall then submit the request including the items or services to be purchased and amount of family or individual consumer participation.

605.3.6 Guidelines for Approving Ongoing Support

In evaluating requests for Ongoing Support, the District Program Manager/District Program Administrator (or designee) shall consider the following factors:

a. Availability of funding

b. The likelihood that Ongoing Support will enhance the family's integrity, prevent the need for residential placement, avoid a more restrictive placement, or foster a smooth transition to more independent living for an adult with a developmental disability

c. The age and/or health status of the parents/family members

d. The complexity of the consumer's needs, the stress that these place on the family and the family's ability to respond

e. The degree of consumer or family participation in the cost of services relative to their means

f. The anticipated duration of the need for service

g. The degree to which the family/consumer is already receiving other Division funded services

h. Other resources that may be available to the consumer/family

The District Program Manager/District Program Administrator shall approve the response to a request for Ongoing Support funds within fourteen (14) working days of the recommendation by the Support Coordinator and Planning Team.

605.3.7 Payments

Authorized services, vendor payments and co-payments are identified on the Individual and Family Assistance Request Worksheet and Agreement. They must be ongoing payments.

The Ongoing Support Payments may only be made when the initial/prior payment has been verified as expended for the authorized purpose (receipts, or when not available, then via a written, signed statement by the recipient individual consumer or family or upon receipt of a bill, rental agreement, invoice or quote from a vendor). In some cases, receipts totaling less than the advanced sum will result in a reduction of the subsequent payment of the Ongoing Support award and will require a return of the unspent supports.

Ongoing supports for food for consumers living in an Individually Designed Living Arrangement do not require an automatic reduction in the ongoing monthly support unless an ongoing trend in unspent Support is demonstrated, in which case the Support Coordinator shall make a re-determination regarding on the level on Ongoing Support required. Receipts exceeding the authorized

amount will not result in an increase in the subsequent payment. In-kind contributions including volunteer time must be documented in writing and submitted along with the receipts.

605.3.8 Waivers

Waivers of any Ongoing Support procedures, including consumer or family participation requirements, may be granted by the District Program Manager/District Program Administrator, if the goals and intent of the program are otherwise met.

The consumer/Individual, Support Coordinator or Planning Team may initiate a written waiver request. The request must identify the specific requirements to be waived. The District Program Manager/District Program Administrator will determine whether approval of the waiver request will enable the goals and intent of the program to be met. The District Program Manager/District Program Administrator will respond to the initiator of the request, in writing within ten (10) working of receipt of the request.

605.3.9 Supplemental Payments Program

The Supplemental Payment Program provides a $70.00 per month payment for housekeeping services for Division consumers who meet the following eligibility requirements:

a. The eligible consumer must receive Supplemental Security Income payments. If for any reason Supplemental Security Income payments stop, Supplemental Payment Program eligibility is denied.

b. A statement dated within one year from a physician that diagnoses a disability must be in the consumer's file.

c. The need for housekeeping tasks (based on the definitions that follow) must be in the consumer's file and may be in the form of:

    1. Deficiencies on the housekeeping section of the Inventory for Client and Agency Planning.

2. Intake document specifying deficiencies in the area of "capacity for independent living".

3. Other assessments or documentation that specifies the need for housekeeping services.

The following guidelines should be considered before making referrals for Supplemental Payment Program:

a. Long Term Care Services recipients are not eligible for the Supplemental Payment Program.

b. Consumers currently residing in Intermediate Care Facilities for the Mentally Retarded or group homes are not appropriate for the Supplemental Payment Program.

c. Consumers living in independent or semi-independent situations can be referred to the Supplemental Payment Program.

d. Adults living in their parents' home, relatives' home or guardian's home are appropriate for referral for the Supplemental Payment Program.

e. Consumers living in Adult Developmental Homes may be appropriate if the home does not provide housekeeping.

f. Children living with their parents may be appropriate under the following circumstances:

1. The child has severe multiple disabilities and requires so much care that the parent(s) is unable to do housekeeping chores.

2. The child is medically at risk and extraordinary housekeeping is required to keep the home safe and clean for the child

3. The child frequently engages in behavior that requires constant supervision from the parent, leaving inadequate time for housekeeping or

the child engages in behavior that is so destructive and/or messy as to require extraordinary housekeeping measures.

g. Children living in Licensed Child Developmental homes and foster homes are not appropriate.

Applications for the Supplemental Payment Program are made through the Support Coordinator and are forwarded to the Central Office for approval (Appendix 600.H). The District Program Administrator/District Program Manager shall approve all applications for children. Central Office shall receive the application after District approval. The following questions should be considered when requesting and approving the Supplemental Payment Program for children:

a. Who currently is doing the family's housekeeping?

b. Does the child do any housekeeping?

c. What types of disabilities does the child have and what special attention is needed?

d. How would the Supplemental Payment Program benefit this family?

e. What types of duties would the housekeeper perform?

f. How many people currently live in the home?

An employer-employee relationship exists under which FICA and federal income tax must be paid on wages earned if an independent provider is paid for housekeeping services. A Fiscal Intermediary is available for this responsibility.

The agency is responsible for all taxes if an agency is paid to provide housekeeping services. People who are age 65 and over and who are in need of other Supplemental Payment Program benefits (Home Health Aide and Visiting Nurse Services) should be referred to the Aging and Adult Administration.

606 Home Modifications

606.1 Overview

Home Modification is the process of adapting the home to promote the independence and functional ability of persons with disabilities. Adaptations may include physically changing portions of the residence to create a living environment that is functional according to the individual's specific needs. Terms often associated with this process include barrier removal, architectural access, assistive technology, retrofitting, home modifications, environmental access or universal design.

Consumers who are eligible for the Arizona Long Term Care System are also eligible for medically necessary home modifications for architectural access to and within his/her natural/private home. The goal of a home modification is to provide the person greater independence and ability with assistance for daily living in their home.

Home modifications must be medically necessary, cost-effective and reduce the risk of an increase in home community based services or institutionalization.

A Home Assessment will be done to develop an individualized home modifications plan. The plan will ensure that only appropriate diagnosis related modifications be completed in the home. This plan also provides for a cost-effective, predictable, medically beneficial and measurable rehabilitative service for the consumer.

The Division must approve or deny requests for home modifications within 14 calendar days from the “identified need date”. A request that requires an additional extension for up to 14 days and is in the consumer’s best interest, requires the consumer receive written notice including the reason for the extension. The Support Coordinator should request an assessment via the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process when attempting to identify the most appropriate modification for the consumer. The Planning Team identifies the need for a home modification assessment only. The assessment must be completed within 30

days. A certified staff person must conduct a home visit to make this assessment. The “identified need date” is determined at the time the team agrees to the recommendations as a result of the assessment.

When a request is for a specific home modification such as a curbless shower, "handrails," widen doors etc., the Support Coordinator via the Planning Document can make a request for that specific modification. The “identified need date” starts at this time and the request for home modifications must be approved or denied within 14 days. A request that requires an additional extension for up to 14 days and is in the consumer’s best interest requires the consumer receive written notice including the reason for the extension. This method may result in a denial of service. The home modification unit would make a broad “contingent” recommendation if sufficient evidence is present to move forward with the request.

606.2 Scope of Home Modifications

The unit of service is one home modification project. Using the consumer’s primary and secondary diagnoses in conjunction with a home evaluation, a project plan to provide home modification for the person will include, but not be limited to, the following areas of the home: The:

a. Consumer’s bedroom

b. Most appropriate, cost-effective bathroom

c. Most appropriate, cost-effective entrance/exit to the consumer’s home, i.e., a ramp.

d. Most appropriate, cost effective locations of the kitchen area, when determined to be medically necessary when the consumer lives alone.

The types of permanent installations for architectural barrier removal include:

a. Widening of doorways – entrance and exit to one bathroom and the consumer’s bedroom.

b. Accessible routes to one bathroom and the consumer's bedroom.

c. One bathroom environment; (roll-in/curb-less) accessible shower, roll-under sink, high rise toilet with handrails, handrails and grab bars in accessible shower, has prescribed.

d. One wooden or concrete ramp/low inclined walkway.

e. Kitchen modifications; accessible cooking surface, minimum accessible pantry storage, accessible kitchen sink/faucet. Kitchen modifications are considered medically necessary when the consumer lives alone and cannot independently prepare necessary meals without modifications.

Home Modification recommendations (i.e. curb-less showers) will consider the use of durable medical equipment (shower chair) to be used; the Health Care Services Office can provide technical assistance on durable medical equipment. The consumer must request any new Durable Medical Equipment via their Primary Care Provider (PCP) who forwards the need to their contracted health plan.

606.3 Home Repairs, Home Improvement

General home repairs and maintenance are the responsibility of the homeowner. Home Modifications are for medically necessary environmental access and do not intend to include remodeling for home improvement or home safety. Although home safety is an outcome from architectural barrier removal when home modifications have been completed, it is the responsibility of the homeowner to ensure the home is safe; and to maintain important safe entrances from the home in case of emergency, for all inhabitants. Requests for home modifications that are determined to be for home repairs, home improvement or home safety will be denied.

Repairs will be carried out to existing structures only when the approved modifications have begun and cannot be completed because of unforeseen circumstances. These repairs must be

necessary for building code correction, thereby granting the building contractor the ability to achieve completion of approved medical environmental modifications.

606.4 New Construction

The service covers only modifications to existing structures of an consumer/family owned home where the person resides. consumers/families that are planning for a new home are responsible for all the architectural access design/construction of a new home. The service does not cover the construction of additional rooms to the existing structure or provide for an additional bathroom. Technical assistance may be available to help with environmental access.

606.5 Homes Not Owned by the Consumer (Rental/Lease)

The owner of the residence must approve the modifications. When the home being considered for home modifications is not owned but is rented or leased by the family/consumer, documentation providing permission to allow for renovations on behalf of the consumer is required from the landlord/owner. Written confirmation must include agreement of participation, signature of the landlord/owner with indication of ownership and address of residence requested for environmental access.

The Division, in compliance with Arizona Revised Statutes § 41-1491.19.D.1 (azleg.gov/ArizonaRevisedStatutes.asp) will incur the cost to restore the home to the original condition prior to the renovation when the landlord/owner requires such after the individual has vacated the property.

No Title XIX funds may be used to return a home to its pre-modification state as outlined in Arizona Health Care Cost Containment System (AHCCCS) policy (azahcccs.gov/Regulations/).

It will be the responsibility of the landlord/owner to demonstrate that the removal of architectural barriers in the rented unit will result in the inability to negotiate a new rental agreement with another individual or family. The landlord/owner must also demonstrate that it is a financial disadvantage to maintain

environmental access to the rented unit. Additionally, the landlord/owner must demonstrate that the unit will not retain the retail value of a single family dwelling because of the removal of architectural barriers.

606.6 Requirements for Medically Necessary Environmental Modifications

Requests for the environmental access to the person's home must include all the following:

a. The need for environmental access documented in the member's Individual Support Plan/Individualized Family Services Plan/Person Centered Plan.

b. Long Term Care Primary Care Provider order.

c. An assessment by a qualified professional, i.e., occupational therapist, physical therapist or Certified Environmental Access Consultant. The Division's Medical Director must be contacted to review the request if an assessment by a qualified professional cannot be obtained.

d. An authorization by the Home Modifications Manager.

e. The evidence that the consumer resides in a private residence. Consumers residing in alternative residential settings are not eligible to receive Home Modifications.

If the request is denied due to lack of medical necessity, it may be authorized, approved or paid by Assistance to Families funds. Medically contraindicated requests shall not be authorized.

606.7 Procedures

When a consumer has recognized a need for home modifications, a request for a home modification begins by contacting the consumer’s Support Coordinator.

The Support Coordinator will forward the request to the Home Modifications Office using the “Initial Request for Home Visit” fax

form upon receipt of a consumer's request for a home modification. This request must be made via the Individual Support Plan/Person Centered Plan process. A written order by a Primary Care Provider (PCP) is another way to make this request. Requests for a home modification may also be made using a home assessment from a physical/occupational therapist.

At the time of request for home modifications the Support Coordinator shall enter into the case file via the "Individual Support Plan" or the "Change of Individual Support Plan" form, the need for an assessment to determine specific modifications.

The date recorded in the consumer's Individual Support Plan/Individualized Family Services Plan/Person Centered Plan becomes the date for the request for an assessment. This request date determines the beginning of the required 30 days to complete a home visit and assessment. Once the assessment is completed, the team can request the specific modifications and the date of this request becomes the "need identified" date.

The Division must approve or deny requests for home modification within 14 days of the identification of need date. A request that requires an additional extension for up to 14 days and is in the consumer's best interest requires the individual receive written notice including the reason for the extension. Projects should be completed as soon as possible following approval, not to exceed 90 days. Extenuating circumstances that prevent project completion within 90 days of approval will be documented in the consumer's case record.

A scheduled home assessment will be conducted within 30 days after the Home Modification unit in Central Office receives a request. The Support Coordinator must be present during the home environmental assessment.

The purpose of a home modification is to increase a consumer's independence. The home visit will assess the relationship of the consumer's ability to function independently in the current environment as a result of the proposed home modifications. The home visit will also coordinate the Home Modification Packet production.

The home assessment will include:

a. Consideration for consumer's abilities and disabilities based upon aids to daily living.

b. Consideration of information that is obtained from the consumer, family or others in the household and members of the Planning Team.

c. Consideration of hazardous areas of the home based on physical and/or cognitive disabilities.

d. Identification of the Individual Support Plan/ Individualized Family Services/ Person Centered Plan (Planning Documents) needs as they relate to delivering services to the individual.

e. Identification of diagnosis-related modifications.

f. Provisions for necessary assistive devices and durable medical equipment.

g. Provisions for necessary architectural barrier removal.

h. Recording architectural measurements of floor plans and specification sheet.

Review the required documents for the Home Modifications Packet with the consumer's Support Coordinator. This includes:

a. Reviewing the Professional Assessment for environmental access. An Occupational Therapist, Physical Therapist or Certified Environmental Access Consultant for the project can provide the professional assessment. A review may be requested from the Division's Medical Director if a professional assessment cannot be obtained at all or obtained in a timely fashion.

b. Obtaining the Primary Care Provider (PCP) order for the project using the prescription form approved by the AHCCCS at 15 days from the "need identified"

date. After this 15-day period, the Home Modifications unit will send a second prescription form to the PCP with instructions that services will be denied if the prescription form is not received.

c. Obtaining the Project Specification Sheet and Floor Plans. The Home Modification Office will be responsible for the development and implementation of the Project Specification Sheet and drafting of floor plans for each Project. A bid request will be forwarded to the appropriate providers. The Home Modifications Unit will review and award the bid to the approved provider upon return of the proposal.

The following authorities will be used as reference for determining accessibility and defining a living environment that provides greater independence and architectural access for the consumer upon developing the Project Specification Sheet. These include Uniform Building Code Chapter 11 - Accessibility, and guidelines in accordance with the Americans with Disabilities Act. ***Note:*** The Division will only approve medically beneficial, cost-effective environmental access.

Obtain Home Modification Bid(s) - (2 bids should be obtained). The Division will use only a licensed, bonded/insured - B or B3 Contractor/Builder for the accessible renovation of the consumer's residence as defined under Arizona Revised Statues § 32-1101.01. azleg.gov/ArizonaRevisedStatutes.asp

Complete the Environmental Modifications Request Form (DD-211) to track progress of the project. Ensure that consumer's identification information, Provider/Contractor name, cost of service, the signatures of the Support Coordinator, supervisor and District Program Administrator/District Program Manager or designee (cost of service must be indicated prior to submitting to the District Program Administrator/District Program Manager) are included. The project can be approved and started whether or not the form has been completed but must be completed to ensure everyone has knowledge of the project and the project costs.

Submit the project packet to the Home Modification Office for review/approval.

The packet will include the following:

a. Environmental Modifications Request (DD-211);

b. consumer's Planning Documents (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan) indicating need for medical environmental access.

c. Professional assessment dated within time of request or review with signature from Division's Medical Director.

d. Primary Care Provider (PCP) order dated within time of request.

e. Project Specification Sheet and Floor plan (before and after, site plan).

f. Contractor bid.

606.8 Review Procedures

The Home Modifications Manager will ensure the District representative has reviewed costs and signatures are present upon receipt of the Project Packet.

The Home Modifications Manager will review and sign the request only upon verification that all necessary documents have been provided.

A second level of approval will be required if a Home Modification Project Packet has a total project cost greater then $9000.00. The Home Modifications Manager will forward the project packet to the Assistant Director or designee for review and a final decision. The second level review will be monitored as to avoid delay and maintain project packet progress with in required time frames.